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ABSTRACT

Nearly 1,500 Indian representatives from across the United States attended the 4-day conference, sponsored by the National Indian Health Board (NIHB), to discuss and learn more about significant issues regarding the delivery of health services to American Indians. Each day participants attended workshop sessions to discuss and debate issues related to one of three major conference topics. The major themes and related workshop issues were: legislative issues (National Health Planning and Resources Development Act, PL 93-641: Indian health manpower development: contracts, grants, and intergovernmental personnel assignments: Indian provisions of the Good Stamp Act of 1977: tribal specific health plans: traditional Indian medicine: implementation of the Health Services and Centers Amendments of 1978, PL 95-626: and 1980 Census): human services (alcohol and drug abuse: emergency medical services: patient rights: Indian Child Welfare Act: Indian elderly: urban Indian health care): and mental health (child abuse and neglect: battered spouses: mentally and physically handicapped: mental health: nuclear power development on the reservations). Reports, recommendations, and resolutions of the workshops were delivered to general assembly sessions the following day. Thirty two of the resolutions were officially adopted by NIHB in January, 1980. (SB)

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THE THIRD NATIONAL INDIAN/ALASKA NATIVE HEALTH CONFERENCE

Convened by the National Indian Health Board

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Our front cover is dedicated to the memory of Nathan H. Olney, Yakima artist from the state of Washington, who passed away January 6, 1980.

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"OUR VISION: A JOURNEY TO BETTER HEALTH"

PROCEEDINGS OF THE THIRD NATIONAL INDIAN/ALASKA NATIVE HEALTH CONFERENCE

Convened by

THE NATIONAL INDIAN HEALTH BOARD

Spokane, Washington

July 22-26, 1979

This publication was prepared by
John P. O'Connor and Judith Rosall

Foreword

Since 1976, the National Indian Health Board (NIHB) has sponsored national conferences designed to deal solely with the health care of American Indians and Alaska Natives. The most recent such conference — the Third National Indian/Alaska Native Health Conference — was held July 23-26, 1979 in Spokane, Washington. The previous two conferences were held in Palm Springs, California in 1976 and in Albuquerque, New Mexico in 1978.

Nearly 1,500 Indian representatives from across the country convened in Spokane to discuss and learn more about some of the most important issues regarding the delivery of health services to Native Americans. Many of these concerns were similar to those addressed in past NIHB-sponsored conferences, including: P.L. 94-437 (the Indian Health Care Improvement Act); National Health Insurance; P.L. 93-638 (the Indian Self-Determination and Education Assistance Act); and tribal and urban health board development and management.

In addition to these topics, and in keeping with the conference theme "Our Vision: A Journey Into Better Health", the conference addressed numerous other issues related to the delivery of health care services to Indian people. To accommodate this expanded approach, NIHB altered the format of this conference from past ones, emphasizing participation by attendees in a series of small, specialized workshops.

This format proved highly successful, allowing participants the opportunity to obtain the most up-to-date information available in their respective areas of interest, while also providing them a forum to voice their own concerns about these issues.

Workshop sessions were divided into three categories, with each workshop held twice in an effort to give attendees the opportunity to participate in as many meetings as possible. The first day of the conference focused on legislative topics relevant to Indian health, such as National Health Insurance; Indian Health Manpower Development; Contracts, Grants and Intergovernmental Personnel Assignments; and Indian Provisions of the Food Stamp Act of 1977.

The theme for the second day's workshops was Human Services, and included such topics as Alcohol Abuse; Emergency Medical Services; Patient Rights; and the Indian Child Welfare Act. On the third day, workshops dealing with Mental Health were offered, and included: Child Abuse and Neglect; Battered Spouses; Mentally and Physically Handicapped; and Mental Health.

Not only did these sessions promote an exchange of information through lively discussion and sometimes heated debate, they produced a number of recommendations or resolutions, many of which were officially adopted by the National Indian Health Board at its Winter Quarterly meeting in Tucson, Arizona January 29. These initiatives have and will continue to provide NIHB with valuable tribal direction in its efforts to advocate for the improved health care of Native American people.

Presentations, recommendations, and resolutions developed at the conference are contained in the following pages. We encourage readers to review them carefully, since many of these issues will continue to be essential to the development and improvement of health care services to Indian people.

Since the Third National Indian/Alaska Native Health Conference was a significant success, with its recommendations almost certain to benefit the future development of Indian health care, members of the National Indian Health Board decided at their Spring Quarterly meeting in April 1980 to begin planning for a Fourth Indian/Alaska Native Health Conference to be held in early 1981.

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Acknowledgements

A major event such as the Third National Indian/Alaska Native Health Conference requires the work and cooperation of many organizations and individuals. While space prohibits us from listing everyone that helped with different aspects of the conference, we wish to express our gratitude to the following persons and individuals whose contributions helped make the conference a success.

The Affiliated Tribes of the Northwest deserve special recognition for their hospitality in welcoming conference attendees to the Great Northwest; the salmon bake they put on was a feast enjoyed by all who attended. The members and staff of the Northwest Portland Area Indian Health Board also warrant a special thanks for their assistance in hosting the conference; their efforts contributed to the overall coordination of many different conference activities.

Because of the unique conference format, a great deal of emphasis was placed on information exchanged at the concurrent workshops. Attendees were able to obtain precise, up-to-date information at these sessions as well as voice their own concerns and recommendations on issues pertinent to Indian health. For this reason, we wish to thank the moderators, facilitators, and panel members who contributed their time and expertise to these workshops. We also wish to thank the recording secretaries for their assistance at the workshops.

Much of the material contained in these pages would not be available if not for the efforts of the many workshop reporters that covered these sessions and developed written reports for inclusion in this publication. We wish to acknowledge the following individuals for their assistance in this regard: Bob Anderson; Glenda Archuleta; Lillian Baker; Grace Boyne; Maria Carillo; Robert Carson; Juan Joe Cipriano; Ellouise Degroat; Geri Fox; Kerry Hartman; Roger Herrod; John James; Valerie Jim; Cheryl Kulas; Mike Lincoln; Pete Little; Bill Miller; Linda Navarro; Lorna Patricio; Yvonne Peperzak; Diane Porter; Bob Ryan; Leroy Seth; Arlene Smith; Eugene Smith; John Spence; Wayne Stein; Susie Taylor; and Paul Vanture.

We also wish to thank Mike Longie, Leroy Seth, and Arnie Holt for their photographic contributions to this publication.

Additionally, we wish to thank Linda Bossert for her assistance in the overall preparation of this report.

Finally, and most importantly, we thank the attendees of the Third National Indian/Alaska Native Health Conference; for, without their interest, support, and participation, there would be no reason to sponsor a national forum to discuss the problems related to delivering adequate health care to Native Americans.

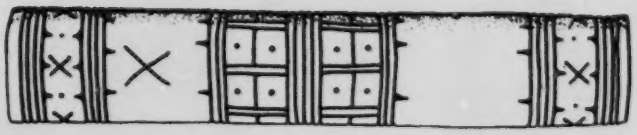

Table of Contents

Foreword iii

Acknowledgements iv

Table of Contents v

Letters of Introduction

Howard Tommie viii

Mel Sampson ix

NIHB: Advocates for Better Indian Health x

FIRST GENERAL ASSEMBLY

Welcoming Address: Howard E. Tommie, Chairman
National Indian Health Board 3

Welcome to Spokane: Mayor Ron Bair 4

Welcome from the Host Tribes: Mel Sampson, Chairman Northwest Portland Area
Indian Health Board 5

Keynote Speaker: Dr. Emery A. Johnson Assistant Surgeon General
Director, Indian Health Service 5

Overview of Legislative Program: Daniel Press, General Counsel
National Indian Health Board 10

Development of
Indian Health Manpower: William Wilson, Executive Director
Association of American Indian Physicians 14

LEGISLATION WORKSHOPS

National Health Insurance/National Health Planning and Resources
Development Act of 1974 (P.L. 93-641) 15

Indian Health Manpower Development 16

Tribal Specific Health Plans and the Implementation of Health
Services and Centers Amendments of 1978 (P.L. 95-626) 18

Contracts, Grants and Intergovernmental Personnel Assignments 19

Status of Area Indian Health Boards 20

Traditional Indian Medicine 21

Indian Provisions of the Food Stamp Act of 1977[3] 22

1980 Census 24

Legal Developments 25

SECOND GENERAL ASSEMBLY

Welcoming Address: Ethel Gonzales, Vice-Chairman
National Indian Health Board 31

Highlights of Legislative Workshops and
Presentation of Reports:

Daniel Press, General Counsel
National Indian Health Board 31

Robert Price, Board Chairman
Indian Food and Nutrition Resource Center 32

William Wilson, Executive Director
Association of American Indian Physicians 33

John Powless, Deputy Director
National Indian Health Board 34

Overview of Human Services Program:

James Smith, Director
IHS Billings Area 40

Presentation by the National Diabetes Advisory Board: Ray Kuehne 43

HUMAN SERVICES WORKSHOPS

Alcohol Abuse 45

Substance Abuse 47

Emergency Medical Services 49

Indian Elderly 49

Patient Rights 50

Title XX of the Social Security Act/Indian Welfare Act 51

Urban Indian Health Care 52

Recommended Changes And/Or Additions To Improve P.L. 94-437 53

BANQUET

Master of Ceremonies: Joseph de la Cruz
Chairman, Quinault Tribe 54

Keynote Speaker: Dr. Everett R. Rhoades, M.D.
Professor of Medicine and Microbiology
University of Oklahoma
Oklahoma City, Oklahoma 57

THIRD GENERAL ASSEMBLY

Welcoming Address: Donald LaPointe
Secretary/Treasurer
National Indian Health Board 65

Highlights of Human Services Workshops and Presentation of Reports:

James Smith Director
IHS Billings Area 66

George Effman, Chairman
National Indian Council on Aging 66

Albert Pooley, President
American Indian Resource Org. 67

John Emelio, Director
IHS Emergency Medical Services 69

Luana Reyes, Chairperson
American Indian Health Care Association 70

Robert Birch, M.D.
IHS P.L. 94-437 Project Manager 72

John Powless, Deputy Director
National Indian Health Board 74

Overview of Mental Health Programs:
H. C. Townsley, M.D.
Director, IHS Mental Health Program
Albuquerque, New Mexico 76

MENTAL HEALTH WORKSHOPS

Mentally and Physically Handicapped 79

Mental Health 80

Child Abuse and Neglect 81

Nuclear Power Development On Reservations 82

Battered Spouses 84

FOURTH GENERAL ASSEMBLY

Call to Order: Howard E. Tommie, Chairman
National Indian Health Board 87

Highlights of Mental Health Workshops and Presentation of Reports 87

Report from Resolutions Committee:
Donald LaPointe, Chairman
NIHB Resolutions Committee 93

Conference Wrap-up and Closing Remarks:
Howard E. Tommie, Chairman
National Indian Health Board 99

CONFERENCE RESOLUTIONS 101

NATIONAL INDIAN HEALTH BOARD, INC.

1602 SOUTH PARKER ROAD • SUITE 200
DENVER, COLORADO 80231
303/752-0931

Howard Tommie, Chairman
National Indian Health Board

Dear Tribal Members and Conference Attendees:

Once again I want to thank everyone who attended the Third National Indian/Alaska Native Health Conference in Spokane, Washington. The National Indian Health Board was glad to sponsor the conference with the assistance of the Northwest Portland Area Indian Health Board. I want to especially thank Mel Sampson and Felicia Hodge for all arrangements made for meetings, social activities, etc. A special thanks to the Northwest tribes for the salmon bake; I know everyone enjoyed it.

The issues discussion and the format differed from previous conferences to assure people that new concerns which have arisen would be dealt with and that everyone would be informed of the consequences. The issue of the enactment of the Indian Religious Freedom Act and its relation to traditional medicine are very much a part of health to Indian people. Nuclear power development in the proximity of Indian reservations is something that everyone is concerned with. The workshops in these as well as other areas were well attended.

Many of the past issues which involved Indian health were re-established and clarified as to the national Indian position (National Health Insurance, P.L. 93-641, the Indian Health Care Improvement Act, etc.). The large attendance at a conference such as this indicates to us that many Indian people want to be involved on many of the decisions that have to be made in the area of Indian health. The National Indian Health Board will continue to promote communications for Indian people on important Indian health issues until we meet again.

I thank everyone for their cooperation and understanding at the conference. When the next conference is called, the board is willing to take suggestions for improvement.

Sincerely,

Howard E. Tommie
Chairman
National Indian Health Board

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

1220 S.W. MORRISON • ROOM 510 • PORTLAND, OREGON 97205
(503) 228-4185

Mel Sampson, NIHB Portland Representative

The Northwest Portland Area Indian Health Board (NPAIHB) in all sincereness wishes to take this opportunity to commend the National Indian Health Board (NIHB) for selecting the great Northwest for the Third National Indian/Alaska Native Health Conference. Furthermore, the NPAIHB was very pleased to assist NIHB in hosting the health conference, which was conducted in a very professional manner.

A conference of this magnitude, concentrating around a subject matter that is very dear to Indian people, obviously requires considerable amount of planning. As is the case with all Conferences, whether they are Indian or otherwise, it is very difficult to allocate adequate time for all the major issues that have to be addressed. The format that was devised for the health conference was an excellent structure, allowing participants the opportunity to actively participate on a wider scale.

It appeared that the overall success of the conference was well received. When NIHB compiles the constructive recommendations from this conference to assist in planning the fourth health conference, it only stands to reason that it should be a greater success.

Since health-related issues for Indians may change or new ones may develop in the course of time, it remains apparent that Indian people should be kept aware of their status. These concerns, in my opinion, determine the justification that the health conference should be held on an annual basis or within a predetermined amount of time each year.

On behalf of the Northwest Portland Area Indian Health Board, we are very pleased to have been an active part of the conference. We also hope that the participants gained more knowledge in the health related field and thoroughly enjoyed our Great Northwest and Spokane, Washington.

Respectfully submitted,

Melvin R. Sampson

Melvin R. Sampson, Chairman
Northwest Portland Area Indian Health Board

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The National Indian Health Board: Advocates for Better Indian Health

Since its formation in 1972, the National Indian Health Board (NIHB) has advocated that health care services delivered to American Indians and Alaska Natives should be of the highest quality and of sufficient quantity to enable Indian people to attain an equal or better health condition than other American citizens.

As a means of achieving this, NIHB is organized to review and comment on all national policies proposed by the Indian Health Service and other federal agencies which serve or should be serving Indian people, and to make American Indians and Alaska Natives aware of services provided by those agencies.

The primary thrust of NIHB activities has been in developing projects related to Indian health programs and provision of advisory, consultative and guidance functions for the Indian Health Service (IHS).

Its Board of Directors meets quarterly to perform review and advisory work. Board resolutions on health-related matters later form a guide for IHS-Indian relationships in health affairs. Along with the direction which comes from its own members and their constituents, NIHB has been given the priorities and initiatives of the Indian health community at large through its three National Indian/Alaska Native Health Conferences.

Composed of 11 members, the Board of Directors represents all but one (the Aberdeen area board disbanded in April 1979) of the geographically-defined regional IHS areas, with representatives selected by their area health boards.

In its advisory capacity, NIHB advises the Director of Indian Health Service on matters impacting on the IHS/Indian relationship in health affairs including, e.g., National Health Insurance, the interrelationships between P.L. 94-437 (the Indian Health Care Improvement Act), P.L. 95-626 (the Health Services and Centers Amendments of 1978), P.L. 93-638 (the Indian Self-Determination and Education Assistance Act), and the National Health Planning and Resources Development Act (P.L. 93-641).

NIHB also reviews Indian health budget materials, implementation activities of the Indian Health Care Improvement Act, IHS policies and procedures and complaints of Indian consumers and beneficiaries.

Its staff continue to closely monitor National Health Insurance developments, and working closely with its National Health Insurance Core Group (comprised of national Indian organization representatives and tribal community-based experts) are seeking to ensure that the Indian viewpoint is included in whatever plan is finally adopted.

The same group also studies the ongoing tribal implications of the National Health Planning and Resources Development Act (P.L. 93-641) and is working to establish mutual understanding with the Bureau of Health Planning, the agency which oversees the act's implementation. The Core Group was successful in having as part of the 1979 Amendments to P.L. 93-641, a section providing that Health Systems Agencies (the 641-created health planning bodies) shall "carry out their responsibilities in a manner that recognizes tribal self determination".

In its advocacy role for the improved health and welfare of Indian people, NIHB has also made its position known appearing either before commission or congressional hearings, on full funding of the Indian Health Service budget and the Indian Health Care Improvement Act; urging passage of the Indian Child Welfare Act; and seeking greater safeguards for Indian people involved in health research before the National Commission for the Protection of Human Subjects.

And with the assertion that Indian people deserve to share much more in the knowledge accumulated from the immense amount of scientific research which has been done on them NIHB, in conjunction with the National Science Foundation and Colorado State University, sponsored two conferences bringing together scientists and researchers with interested Indians and Alaska Natives.

NIHB has also become closely involved with Indian hunger and nutritional issues through working with the National Indian Food and Nutrition Resource Center Board, a group of Community-based people working in the Indian nutrition field chosen at the 1977 convention of

the National Congress of American Indians. Working under NIHB auspices, this group has set up the National Indian Food and Nutrition Resource Center, with central offices located in Denver, Colorado. The center provides tribes with technical assistance for securing control of their own commodity distribution and food stamp programs as provided for in the 1977 Food and Agriculture Act.

Through numerous mailings and through its monthly newsletter, the *NIHB Health Reporter*, NIHB has reported on significant developments related to Indian health and kept its readers informed about the implications of the subjects involved. NIHB staff persons are available to provide additional information or assistance as requested by tribal groups, health departments, and boards.

With an eye to Indian Self Determination and strengthening community health resources, NIHB has grown increasingly interested in offering training to members of Indian health boards. In cooperation with the IHS Office of Research and Development, NIHB will shortly begin training interested area Indian health boards, later expanding the program to local health board members.

In the future, NIHB will continue to stress cooperation and interaction, not only with IHS, but with tribal organizations and Indian health organizations which share the mutual concern of improving the health status of American Indians and Alaska Natives.

REPRESENTATIVES AND ALTERNATES to the National Indian Health Board at their Spring Quarterly Meeting in Bangor, Maine (April, 1980). Pictured left to right are: Howard E. Tommie, NIHB Chairman and USET area representative; Donald LaPointe, Bemidji area representative; Lawrence Snake, Oklahoma City area representative; Elwood Saganey, Navajo Nation representative; Timm Williams, NIHB Vice-Chairman and California area representative; Jesse James, Billings area alternate; Agnes Nichols, Alaska area alternate; Maxine Dixon, USET area alternate; Effie Dressler, Phoenix area alternate; and Ethel Gonzales, NIHB Secretary/Treasurer and Alaska area representative. Also shown with the Board is NIHB Executive Director Jake Whitecrow. Board members not pictured here are: Narcissuss Gayton, Albuquerque area representative; Daniel Foote, Billings area representative; and Mel Sampson, Portland area representative.

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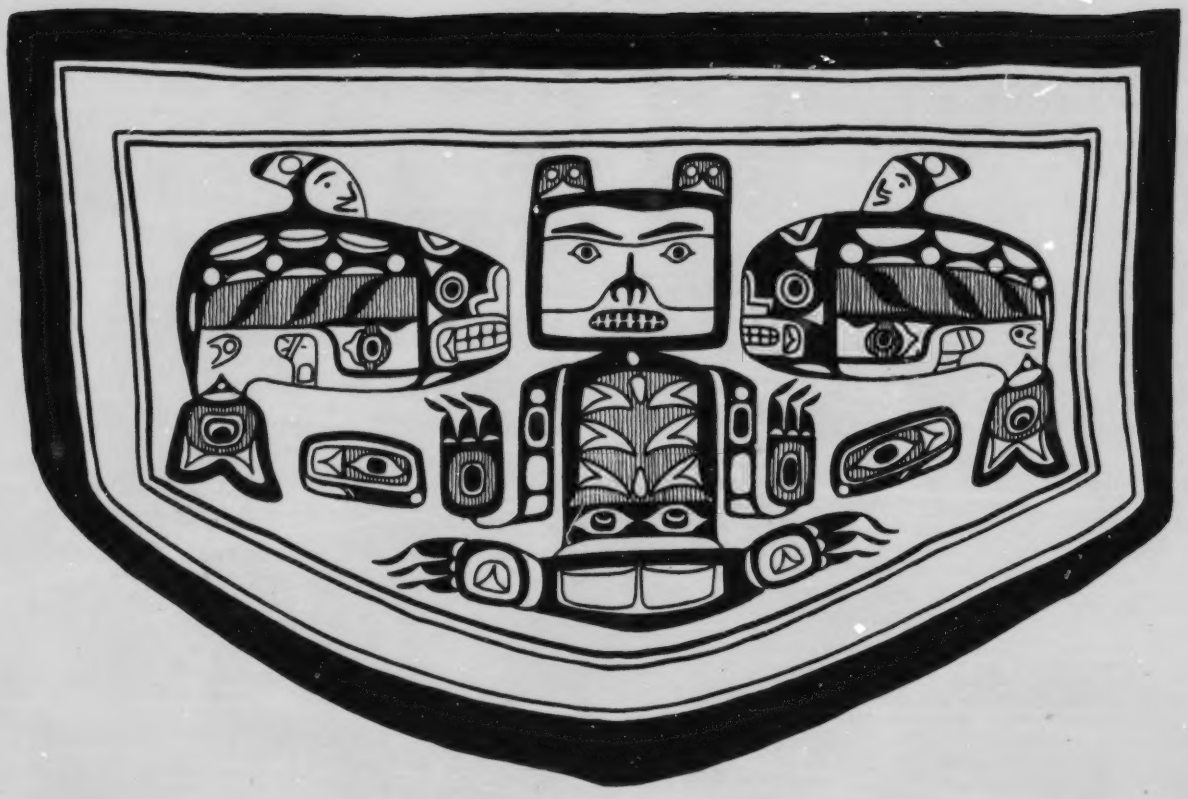
Monday, July 23, 1979



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First General Assembly

HOWARD TOMMIE: Ladies and gentlemen, as chairman of the National Indian Health Board, I would like to call the Third National Indian/Alaska Native Health Conference to order and I will ask all of you to stand for our flag presentation by the Northwest Tribes. Please remain standing and Delbert Frank will give us our invocation.

DELBERT FRANK: (Whereupon the invocation was given in Mr. Frank's native language.)

HOWARD TOMMIE: Ladies and Gentlemen, my name is Howard Tommie and I'm chairman of the National Indian Health Board. I represent the United South and Eastern Tribes. I am a Seminole from Seminole, Florida, and we have various representatives from each area that we are going to introduce.

At this time it gives me a great deal of pleasure to see the many people who have arrived here; some have travelled from far distances; some have travelled by car; some have travelled by airplane. Any way that you have made arrangements we are glad that you are here.

This is our Third National Health Conference and the previous conference gave us a real good indication that a conference of this type is very, very beneficial for the type of responsibility that the National Indian Health Board is charged with. It's charged with the best consultation that we can promote with all of the Indians located in different parts of the United States.

In a continuing effort to provide consultation, this is our third conference and our board members are very pleased that they could promote such a conference.

The board consists of representatives from twelve regions. The board itself has given up a lot of time and effort from their own jobs to come to different meetings that we have in different parts of the country to find out the best way that we can promote better health for Indian people.

I'd like to introduce our board members. From the Alaska area, Ethel Gonzales. From the Albuquerque area, George Platero. From the Bemidji area, Donald LaPointe, one of the heavyweights of the national board. From the Billings area, Daniel Foote. From the Tucson area, Linda Lejero. From the Phoenix area, Billy Kane. From the host area of the northwest our representative is Mel Sampson. The California representative is Timm Williams. The Oklahoma representative is Lawrence Snake. The Navajo representative is Elwood Sagney.

During the conference, Mel Sampson is the chairman of our planning committee, and if there are any questions you can look to myself or Mr. Sampson.

I think the board is interested in having a public hearing type of think concerning the workshops. I think that we can go both ways. We can give you the information in the workshops but we also emphasize that you, if you do have some problems in your area or you see some improvements that could be made in some of these areas or maybe it's along the type of work that the board can do, this is what we're interested in, and, I think, by looking at the agenda today you have a very good wide variety of workshops to choose from.

Of course, we realize that there are a lot of people interested in some of the workshops that are going to be held at the same time, but I hope that somebody from your tribe can attend at least some of the workshops that are being held.

I think that the planning committee has done an excellent job. They have provided all kinds of entertainment and they have also given us a very good selection for the banquet speaker. I hope that everybody will get a chance to attend the banquet Tuesday night.

I think many of the activities are the result of great effort by the planning committee and I hope that everybody will make a point to attend many of the functions, tonight especially when we have the salmon bake.

I guess the agenda pretty well explains itself and what our concerns are. Last year when we addressed the conference we had various types of problems that the Indian people had to deal with. At that time we were unsure of issues such as backlash and all the other issues that were presented to us. The Indian people were assured by representatives from the federal government, congressional people, that many of the types of issues that were being brought up could be on a compromise basis. I think that not so much has been compromised to the extent that it would deteriorate many laws of the government and also protection of the Indian people, but, also for the peaceful coexistence between the Indian people and the general public.

Today we have different types of programs and also policies that have been handed out and we particularly would like to go over some of those that are affecting the Indian people. I think that the National Indian Health Board is very well aware of the difficulties that have hampered many of the Indian people from participation in some of these programs.

Of course there are other items that are facing the Indian people today and I think that many of the issues will be addressed from time to time by the National Congress of American Indians, as well as the National Tribal Chairmen's Association. Our board will be very interested in health policies that these organizations can adopt

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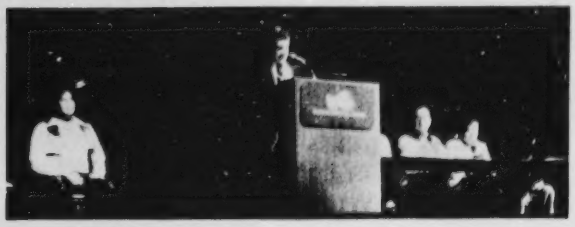
so that we may be able to address them to our health constituents throughout the United States, the Indian community throughout the United States.

I am encouraged by President Carter's recent appointment of Ms. Harris as HEW Secretary.

I remember Ms. Harris when she made a point to streamline or better understand the program for the people of the United States that needed housing when she was with Housing and Urban Development. I think she attempted to do that and I think if she carries out her policy within HEW and tries to streamline so we can read some of these laws according to the HEW guidelines, I think we are going to have somebody in there that's on our side as far as trying to interpret some of the rules and regulations, but that remains to be seen.

At this time, I would like to introduce Ron Bair, the mayor of this fine city.

RON BAIR: It is an honor and a privilege for me to welcome you to our city as you convene for your Third National Indian/Alaska Health Conference. I hope that the city of Spokane will provide a good home for your convention and that your conference objectives will not just be met but truly exceeded at this session.



SPOKANE MAYOR RON BAIR welcomes attendees of the Third National Indian/Alaska Native Health Conference to the Great Northwest.

The Native American people were a powerful founding force in the Spokane area and we must never forget the culture and traditions which are our heritage in this community; a heritage that we can be proud of and strive to maintain. Spokane is rich with Native American history and was the site of the first American Indian convention when all the area tribes gathered together at the Spokane Falls for the common purpose in the spirit of brotherhood and named us after their tribe, Spokane, Children of the Sun. So it is particularly appropriate to hold your convention here in Spokane because you are a vital part of this community, both from a historical perspective and in present time as well.

It is present health problems and legislative issues relating to those problems that we should focus our attention on during this convention. These complex issues are of utmost importance to every individual in this community because each race interacts with another and that which affects one race ultimately touches us all.

I hope that you are able to deal with supplementing your existing programs to suit current needs and that your work will be advanced by this four-day meeting. During the convention I hope it is not all work but you do find a little time for play. I suggest that you try to make the time to do some sightseeing in the city, visit the park next door, the shops, the restaurants.

Thank you for inviting me to be with you this morning. It is an extreme pleasure to officially welcome you to Spokane.

MR. TOMMIE: Thank you, Mayor. The National Indian Health Board always has and will continue to work closely with the Indian Health Service and its personnel. We are indeed happy that they are supportive of a conference such as the one we have here.

At this time I would like to ask Marlene Haffner, Director of the Navajo Area Indian Health Service to come up and say a few words before we proceed. I would also like, following that, Dr. Stitt, he's area director from the Portland area and hopefully we can call upon either one to give us assistance in whatever the conventioneers would like.

MARLENE HAFFNER: The Indian Health Service has always been very pleased and honored to be a part of these national conferences.

In this year's conference, as you look through your agenda, you will see that the area directors are being involved either as moderators or facilitators in many of the workshops. In addition, there are a number of chief staff members from Indian Health Service head-quarters and from around the various areas who are involved with the area board and the national board members who are included.

A number of the area directors have not yet arrived, I understand, and many of them will be in later today or tomorrow, depending on when their particular workshop is scheduled. However, I would like to introduce the people that I have been able to see here this morning.

Mr. Tommie already mentioned Dr. Stitt. Dr. Stitt is from the Portland area. Out in the audience is Mr. Gerry Ivey. Gerry is from the Alaska Native area. I have also seen out there this morning Mr. Jack Casebolt who is the Director of the Office of Program Planning for Indian Health Service.

I saw Jim Danielson, Director of the Office of Program Support, earlier today. Also I see Dr. deMontigney, Director of Division of Community Resources and Community Development. Mr. Bud Mason is here also from the Office of Alcoholism. And, Bob Birch, our 94-437 Project Manager.

Are there any other area directors that I have missed? I'm sure you will be seeing many of us around and we would like to thank you for allowing us to participate in this conference.

HOWARD TOMMIE: The host area is the Northwest Portland Area. They have a lot of nice things going on for us and they have put in a lot of

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effort for the entertainment that is going to be carried on during this conference. So at this time I would like to introduce Mel Sampson, Chairman of the Northwest Portland Area Indian Health Board.

MEL SAMPSON: I don't know whether to apologize or to be appreciative of the hot weather that we are having here in Spokane. It's a little unusual, it normally isn't this hot here. Dr. Johnson tells me that it's hot all over.

The Northwest Portland Indian Health Board encompasses the states of Washington, Oregon and Idaho; representing some 34 various recognized tribes. We would like to invite you to share in what we consider one of the more beautiful parts of Indian country, commonly known as the Northwest.

We have taken some great efforts to try to make things a little easier for you while you are here and I hope that everybody has a wonderful time and an opportunity to get out into the outer areas within the states of Washington, Oregon and Idaho. I understand some people did drive in from various parts of the country. As far as I know the gas situation isn't that tough around here yet. If you do indeed enter into some kind of complication, please feel free to contact myself or any member of the area board, and, of course, depending upon what it is, we will see what we can do to assist you.

I would like to bring special attention to the salmon feed that's going to be held tonight. It's being sponsored and hosted by the Northwest Tribes. We've got the potatoes, et cetera coming from the great state of Idaho. We have salmon and other seafood, clams, et cetera, coming from some of the coastal tribes. We have melons and corn coming from all over. It is hoped to be a good salmon feed and it is free to all of the participants who have registered; bring your families.

With that in mind, I share with the honorable mayor in welcoming you to the city and the area.

HOWARD TOMMIE: At this time, following the agenda, I think that Dr. Johnson has survived a couple of administrations, survived many of the Indian tribes, I'm sure, and I don't think he needs any introduction. He has always made himself available to speak with many different tribes and I'm sure that there aren't too many tribes he has not visited. He has familiarized himself with the Indian community so that he can do his job to the best of his ability with the resources made available to him.

At this time I would like to call Dr. Emery Johnson up as keynote speaker for this morning.

DR. EMERY JOHNSON: I'm very pleased to have a chance to be in Spokane with you today to go through with you some thoughts and concerns that I have to see if we can together set the stage for a very successful and very pro-ductive Third National Indian/Alaska Native Health Conference.

I remember the first one, and, in fairness to some of the folks who were involved in it, it was 115 to 118 degrees or something, and Mel, you don't have to apologize for the weather here. Anybody who was at the Palm Springs Conference knows what hot weather is. We've come a long way since then.

You have before you a tremendously complicated and potentially productive four days. I've been reviewing the documents that you have in your folder, the workshops made available. If even a major fraction of the efforts identified in these workshops is, in fact, handled and taken home with you and followed up at home, the status of the Indian health direction in federal Indian programs is going to be dramatically changed and improved.

I'd like to express my admiration to the NIHB board and its executive director and people on the planning committee for putting together what I think is an extraordinarily comprehensive and potentially productive conference. I think it says something for the Indian communities and tribal leaders and the health boards, and NIHB in particular.

When we have health conferences, they're not meetings, they're not just people sitting around in great big groups talking. They are primarily working groups where people will roll up their sleeves and get down into real issues. There are no padded issues in your workshops. They are all serious and they are all important and all need to be dealt with. I think that with the number of people here and with the wide diversity of communities that you represent and that with the cooperation and inter-change that has taken place in previous conferences, and, I'm sure it will take place in this one, that this will turn out to be an extremely productive and valuable landmark for the Indian tribes and their health programs.

The last decade has been an extraordinarily productive period for the Indian tribes and for Indian tribal governments. I think perhaps today the best thing I can do in the brief period of time that I have with you here is to try to see if you can't deal with perhaps three basic questions, three fundamentals, that I think will help us orient ourselves and direct your support toward the future.

The three questions really are: Where are we; how did we get there; and where do we go from here. They are very simple types of questions. Let's see where they start out.

Where can we go from here? Where are we in real terms of the health status of the Indian people? That's what this is all about. This is not a bureaucratic process, this is not an administrative process. The think that we're all here for, you, health professional staff, tribal leaders, urban leaders, whoever is here, we're here because we're concerned about the health of the Indian communities.

Where are we? Turn to the status again. There's no question for any of us who can look back over a period of a number of years that we have come a long, long way. There have been dramatic improvements in the status of the health of the Indian people. A whole variety of health indicators that can help the Indian people have improved substantially and significantly and dramatically within these last few years.

It used to be that the Indian community in almost any measure that you used was behind in terms of their health status. That's no longer true. The health of Indian people in many areas and in many different categories of illnesses, the health status is better than that of many of the populations in the United States. There are, of course, still some serious areas of deficit and we'll deal with those a little bit later.

Where are we? We come to the point where many of the more serious diseases of the past have been put under control. Where we now are dealing with diseases that are to a large extent beyond the significant control of the health system, the health profession as such. Things that are problems now are not issues that doctors and nurses of themselves can really deal with. There are things for which you can be helpful, can be supportive, but the real change, the real improvements, are going to have to take place through activities within the community. We'll talk about those when you say where do we go from here.

There's no question that in this last decade we've seen a dramatic improvement in the comprehensiveness of the program. We have recently been involved in maternal child health, mental health and alcoholism. We have a number of new professional personnel, greater access on the part of the community to health care. We have in most Indian communities now some members of the health team that are there on a permanent basis or on a periodic basis. We certainly have new facilities, many new clinics, new hospitals, new mobile units, a number of different ways to attempt to improve access on the part of the Indian Health Service.

We have a number of new Indian communities that are now part of the health program, communities, for one reason or another, that had not been participants in the federal Indian health programs, including such groups as the St. Regis Mohawks, the tribes in Oklahoma, California tribes that are now participating in the program when 10 years ago they were not a part of it.

The comprehension in terms of what's available, both on the reservation and urban basis, can broaden access into additional tribal people that are involved, including the special programs for urban Indians. Remember 10 years ago urban Indians were totally excluded from the program but as a result of congressional action we now have some 40 urban communities that have Indian health projects.

The third perhaps major change, that has taken place in the last 10 years has been the dramatic increase in the involvement of Indian tribal organizations in the health program. We've had for a number of years health committees and Indian health boards and we've had health departments and now we have tribes that are actually out there running hospitals, they're operating clinics, they're out there operating preventive services. You name it, someplace in this country there is an Indian tribe that is doing it.

We have a substantial structure that's been developed by tribal governments and by the urban Indian organizations that know what's going on in health. They've done their thing and they know how to do it and they're doing a very credible job. As we were saying the other day in talking to one of the tribal leaders, none of us could have imagined even five years ago the dramatic change that would take place in tribal involvement in programs, not just talking about things but doing things. I think perhaps that's the most significant, that tribal governments are now "doing", not just talking and advising.

How did we get to this particular stage in life where we have dramatic improvements in Indian health status; where we have greater comprehensiveness and access of health programs; where we have a significant tribal involvement in delivery, planning and evaluation of the health programs? How did we get here?

Well, obviously, we got here through the legal and legislative process, through the Constitution of the United States which reserved under the Congress the right to treaty with the Indian nations, the hundred years or so of treaty making, the next hundred years of lawmaking. Remember I talked about the treaty-making process in health care. To quote Sitting Bull who said, "The white man made many promises, he kept but one. He promised to take our land and he took it." Now that is a sad but true story of the treaty-making era and yet for all of the tragedy it left it does provide the basic foundation for whatever we have now and whatever we may hope to develop in the future.

We have the Snyder Act, which was very broad and yet not very precise in many respects, not a very helpful definition of our authority. The Secretary may dispense such funds, as Congress from time to time may appropriate, that certainly doesn't tell you very much about what the federal government commitment is to the Indian people in general and health in specific. Many of us in the health programs, tribal leaders and others, were concerned about the fairly vague position that the federal government is taking in Indian health and in Indian affairs in general.

As a result, we've had in this decade a couple of landmark pieces of legislation. The first one, we all know, was the Indian Self-Determination and Education Assistance Act, 93-638. For the first time this put into public law tribal governments

having the right, as well as the opportunities, to make their own decisions, to operate the programs for their people rather than having the federal government do it, or, at the same time the right to say, "Let the federal government do it and we'll tell you what to do and see how you do it and make sure you do it right." So, 93-638 was, in fact, the major turning point in the entire federal-Indian relationship.

Following up on that is what we've always considered a companion piece of legislation, 94-437, the Indian Health Care Improvement Act. For many people, many tribal leaders, and those of us who work with them, we're concerned with the Indian Self-Determination Act in the sense that what advantage is it for tribal government to take over a program which is inadequately funded, poorly housed, which is marginal at best? What chances does the tribal authority have in having a successful program for the people? If you take over as a tribe that kind of program aren't you, in fact, setting yourself up for failure? We've kept the position that if the federal government is serious about Indian self-determination, then it needs to put its money where its mouth is.

Try to define in law what the federal relationship was with the Indian people in terms of the health programs; what the federal responsibility was; the scope of the programs and the scope of services that should be made available to Indian people; what quality should be provided in that health program; and, how it should be developed in support of the tribal communities. That was really the concept behind the Indian Health Care Improvement Act, and, as we all know, in the legislative process there are many changes from the original concept of the final bill.

By and large, the Indian Health Care Improvement Act has defined fairly well the fundamental federal relationship between the Indian people and their health and it has made a commitment that the federal government has a responsibility and the Indian people have a right to obtain health services supported by the federal government. They have the right to obtain a comprehensive health delivery system. They have the right to expect high quality and they have the right to be as fully participatory in this activity as they in their own initiative choose to be.

So it was a fundamental landmark position taken by the Congress, because remember when we go back to the origin of this relationship the Constitution of the United States says that Congress reserves unto itself the right to treaty with the Indian nations. So anytime that we get into an issue of what is that federal relationship with the Indian people we must go back to Congress. Congress has established the relationship and Congress either nurtures that relationship or avoids it or whatever.

Where do we go from here? There are a number of circumstances in the last few years, particularly in the last two or three, that gave us some concerns, perhaps. I'll mention them only so that we can all see the potential problems that we have, not to dwell upon them and be overly concerned with them, but, I think you have to understand them.

The first one is one that is affecting all Americans. It's the issue of inflation; the high price of everything we buy; the pressure that that puts on the federal tax dollar; the concern that that has generated among American citizens who have concerned themselves with the federal expenditures, federal taxes.

There is in the country, certainly in the mood of Congress and the mood of the Administration, the sense of caution, a sense of concern about the utilization of tax dollars. Certainly a change from the previous 10 years or so where there was a simple solution to everything and that was to establish another federal program and shovel more federal dollars into the problem and hopefully it would go away. Certainly that attitude on the part of the Congress and on the part of the Administration has changed dramatically. We are now looking at a Congress and Administration who have asked us some very hard and very serious questions about any activity that is going to require the expenditure of federal funds.

The second overriding issue is one that affects much more directly the Indian people and that is the so-called anti-Indian backlash. Again, we don't like to talk about these things and we don't like to deal with them, and you in the Northwest know this very well and certainly people in the Great Plains and some of the other parts, that there is a certain group of people, we believe it's a relatively small group of people, that would turn back the pages of history and renounce the federal commitments to the Indian people, would turn their backs on the dramatic improvements that have taken place and they do that in the name of equal rights and responsibilities or whatever it is at the moment that they are dealing with.

I don't want to dwell on this. We need to understand these things. They are both out there and they are both real but they both can be dealt with. How do we deal with them? Well, it's the issues before you here at this conference, issues that are before you over the next few months, and, in fact, the next several years.

First of all I think that we have many things going for us. Perhaps the strongest foundation that we have is the basic commitment on the part of tribal leaders and their communities, urban Indian leaders, health professionals, that health is important. Health is above and beyond the day-to-day political concerns. Health is something that each and every one of us can make a commitment to and that we can and will move forward towards.

There's a basic strength, I believe, and I believe this very strongly, in the leadership of the Indian communities that say we are not going to be turned aside from our commitment, our determination to improve the health in our community. Health, not only in terms of our own personal, physical and mental health, but in terms of the social well-being of this community, of our tribal institutions, tribal governments, education, community development, social responsibility, whatever it may be. We have that remedy and we're going to deal with it and we're not going to be turned aside by lesser concerns because the status and the entire future of our Indian communities depends upon the successful development of a health community and a healthy population.

That's the message that I get when I talk to tribal leaders and visit Indian communities. It's there, not superficial, but deep down, and it's an abiding thing that they can and will deal with it.

We then have this fundamental foundation of community commitment. What are we doing? What can they do? You have just finished and we have just completed the first nationwide attempt for each American Indian group, to try to figure out where they are; where they've been and where they want to go. It's called the Tribal Specific Health Plan and Urban Specific Health Plan. Over 90 per cent of the tribes did their plans directly and all of them participated. All of the urban groups have gone through this process. It was a monumental effort. Hundreds of thousands of hours have been spent on this. A good deal of financial support was provided for this. It was an effort that many people said couldn't work, wouldn't work, it wouldn't produce good plans. We were told this may be a very hazardous undertaking.

Well, I am very pleased with the results of this process and I believe my faith in the commitment of community leadership has been fulfilled. I've seen a number of the plans so far and quite frankly I'm very impressed. I've talked to many people in the communities that have been involved; planners, tribal leaders. Discussions took place out there in a relatively short period of time, 2½ years is relatively short in terms of federal programs, I'm sure. In this relatively short period of time we've had a dramatic improvement in understanding on the part of the various community groups, on the part of the people we work with.

We now have collected, or, you have provided to us the first national attempt to identify specific needs, directions, hopes, aspirations, plans from the Indian communities throughout the United States. With that combination each tribe now has a benchmark to where you are. You have identified the things that you would like to see done in your community. You have the process started, which, if maintained from here on will provide the mechanism for increasingly effective tribal decision-making in relationship to the health program. It's something that you did, the tribal governments, the tribal communities did themselves. It was not done by the Great White Father in Washington or by some other outside federal agent who has come down to tell you what you ought to do. You have done it yourselves.

The next three or four months, even less than that, perhaps the next two-and-a-half months, is going to be a very critical time for all of us. As we take these health plans and try to use them as a fundamental basis for the Secretary to make — I was going to say his report to Congress — it's now her report to Congress at the end of this calendar year.

The Indian Health Care Improvement Act, I think very wisely did not set out in infinite detail the process or the activities that need to be carried out to obtain the goal of that act. Remember the goal was to eliminate the disparity between the health status of the Indian people and the general population of the United States. To bring the health of the Indian people up to the level of that of the general population. To do that through a process it calls for developing a comprehensive health delivery system that would be responsive to and effectively serve each Indian community. To develop Indian health manpower. To provide the facilities for housing and sanitation and so forth. That was the goal.

The Congress very wisely did not set out step-by-step exactly how that is going to take place. They said, "We'll start with three years, sort of a general approach to this thing, and at the end of three years we'd like to have a specific approach that could be looked at by each tribe." That's really how Tribal and Urban Specific Health Planning came about.

We need to be able to capture the essence in this plan and to hopefully have the Secretary of HEW present to the Congress at the end of December, a comprehensive analysis of where we are, how we got there and where we are going to go from here to obtain the goal of the act, to eliminate the deficiencies in the Indian health delivery system, the deficiencies in Indian health manpower and the deficiencies in Indian housing, sanitation, and so forth, and to provide the leadership, the guidance, the direction to the Congress so that they may appropriate wisely, so they may legislate effectively to improve the health status of the Indian population.

There are many issues that need to be dealt with in that report and it is not going to be an Indian Health Service report or a report on the Indian Health Service. It's a report on health for Indian people and it's very important that you keep that distinction. It's not an authorization bill, it's really to say what kind of activity has to take place in this country in order to permit the Indian tribes, the Indian communities, the urban Indian

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people, to achieve health equity with the rest of this country. We need to look at the legislative concerns.

I'm not going to go through a laundry list because you have them here in your agenda, in your workshops, many of these legislative issues that we've got to deal with. What should the federal policy be? What should the federal direction be in terms of the health plans; in terms of national health insurance; in terms of tribal sovereignty. What's the process so the tribes can come and get direct funding for various health programs, rather than having to trip around through the states?

I could go on and on, there's a whole series of issues that need to be addressed. Hopefully they can be developed through the Secretary's health plan so that the Administration could come to the Congress and say in a very positive sense. "We believe the following things must be done. Here are the things that we are going to do in the Department of HEW."

I think this conference then provides an exceptional opportunity for the Indian people and their staff and their health professional supporters to guide the Secretary's report. I feel that if there is clear direction and clear consensus from the Indian communities as to what needs to be done, how it should be done, I believe that the Secretary will respond appropriately and sympathetically to these issues.

Secretary Califano was committed to this and I think Secretary Harris will be equally. I've known her for some time. We've had dealings with she and her staff. I think we will not see any dramatic changes in policy, perhaps there will be some changes in style but I think the policy support on the part of HEW will continue.

This gives Secretary Harris a unique opportunity to assert leadership on the part of our Administration for the shaping of legitimate Indian and national goals. I believe that if we together provide her with a well-developed report, show her the tremendous participation, support, the thought that's gone in on this from the Indian communities, that she will give it careful and sympathetic review and that we will get a good report sent to the Congress.

If this can be done, and I have every confidence it can be, we are going to have from the Administration to the Congress a clear mandate for a quality health program for Indian communities, a commitment to compassion, concern, to consistency, the kind of high quality, of sensitivity, responsiveness that each of us would want. The plan of health services that each of you deserve. The kind of protective partnership that is, in fact, the only way that we can overcome the objects that time and history and distance have placed in our way.

This effective partnership has been laid down by the commitment of tribal leaders, commitment of the health people, the Indian Health Service and other health organizations, and the tribes themselves over the past number of years. That effective partnership is here and all need to do is pick up from where we are today and follow the trail that has been set before us.

NIHB ALASKA REPRESENTATIVE Ethel Gonzales and IHS Director Dr. Emery Johnson take time to confer following recess of the First General Assembly.

I wish you well this week. You have a long, hard and difficult four days planned but the potential for you and your communities is almost unbelievable. If we can do this effectively, I believe Congress and the Administration will still support the legitimate aspirations of the Indian people.

I wish you well from my staff and from all of us who will do everything we can to give you all the support that we can over these next months and years.

HOWARD TOMMIE: I think there might be need for some clarification on the resolutions process that we are going to apply a this conference. At this time I want to, before we continue on, get Don LaPointe to come up and explain the resolutions procedure.

DONALD LAPOINTE: I'd like to ask each of you to look into your packet in which there should be a copy of the resolutions procedure. First, I'd like to announce that resolutions can be turned in at the Board Room which is located on the third floor in the Sheraton. Resolutions will be received each day of the conference until four o'clock. We're asking that you follow a little bit different format in submitting a resolution this year.

First, we're asking that resolutions deal with that particular day's topic. The resolutions will not be acted upon at this conference, but, instead will be carried back to the various areas for action by local boards and then sent back to the National

Indian Health Board and acted upon at their next meeting to take place in August.

We welcome your resolutions and if you follow the directions in the packet I'm sure that the resolutions procedure will flow. If you have any questions, come in and talk to me or the people on the resolutions committee and we'll try to help you in any way that we can.

HOWARD TOMMIE: Also, before we go into our next speaker, the staff has got some things that they have to do and I'm pretty sure they're going to be leaving. I'd like to ask John Belindo to come up and introduce his staff, I think at 9:30 they have a press conference. John Belindo is our executive director and he's responsible for the overall operation of the central office in Denver. The board depends a great deal upon his staff to make sure that everything runs smoothly.

JOHN BELINDO: The staff of the National Indian Health Board does welcome this opportunity to be of service to you during these next few days. A lot of our staff members are across the way in the registration area. A lot of coordination is now taking place for a press conference and several people are working on the coordination of various workshops. Some of the staff persons may not be in here and I'll just call your name and if you're here in the audience please stand.

The Deputy Director of NIHB is John Powless of Oneida, Wisconsin. Is John here? Other staff include Rick Nordwall, who is our program analyst; Howard Bad Hand, who is program analyst for National Health Insurance and 641; John O'Connor who is the assistant to our Director of Public Information, Linda Bossert. Linda is making the preparations for the press conference which will be held at 9:30 this morning. Trudy Ware, who is the board coordinator; and serving as co-chairman as conference coordinator is Felicia Hodge, Executive Director of the Northwest Portland Area Indian Health Board.

The secretarial staff, whom you'll meet, I'm sure, during the next few days, are: Angela Begay, Gail Notsinneh, Angela is a Navajo, Gail is a Jicarilla-Apache; Marie Bordeaux, a Sioux; Brenda Wilson, a Sioux. Are they here this morning? I think they're in the registration area, as well. We also have with us our general counsel for the National Indian Health Board, Dan Press.

If there is anything that you need that we can provide in terms of supplies or additional materials that you will require, please feel free to contact any of these persons.

HOWARD TOMMIE: Moving along, Dan Press is our general counsel. We kind of look to him to look out for us in Washington.

DANIEL PRESS: Members of the board and representatives from the 50 states: It's a pleasure to be here this morning to be a part of what promises to be an exciting and extremely productive conference.

My assignment this morning is to provide an overview for the legislative workshops that will be going on this afternoon.

A couple of months ago there was an article in the *Washington Post* by a newspaper writer somewhere out west who had spent a couple of years in Washington summarizing his feelings about the city and about the government. From his perspective he said, "The people in Washington have a lot of information, have a little knowledge, and have no wisdom." I think that's a good theme for the legislative session that's going to go on in workshops this afternoon.

The executive branch of government, the judicial branch of government, are providing the leadership for this country and will be giving you a lot of information, probably more than you can digest. I think we have an excellent team of moderators and facilitators and they will be giving you some knowledge also.

The wisdom is not in Washington. The wisdom is among the people in the audience and behind with the people back home at the tribal level. The challenge for you this afternoon is to take the information and the knowledge back home and have the wisdom to put it to work in a manner that is appropriate for your particular tribe and your particular values and your particular approach, source of development of health. Only you can take the legislation, the administrative decisions, the judicial decisions, and make them compatible with your own larger vision of developing your tribe and your visions for the better health of your people.

I think Dr. Johnson slipped when he set some of the mood for what is happening in Washington. In some ways I disagree with his analysis. There have been several years of anti-Indian backlash, and it has had some very serious repercussions out here in the field, particularly in states like Washington and Oregon, but my experience has been that it has not been a major factor in influencing legislation in Congress. I think it's been a lot more rough than it has had actual negative impact. I think it's fair to say the backlash advocates have been pretty unsuccessful in trying to undercut the special relationship that exists between the Indian people and the federal government. It doesn't mean that we can sit back and ignore it. I think you can feel very satisfied that we are giving them a good fight.

Dr. Johnson is right that the big factor in Washington now is the fiscally conservative attitude of Congress, the unwillingness of Congress to continue to spend more money each year on federal programs. That has a very serious impact on Indians along with other people in this country who depend on the federal government for services of various kinds.

It means basically that there'll be no new programs, and probably means that there'll be no significant increase in the budgets of the existing programs to allow you to expand and in some cases to allow you to keep up with inflation. So I think that one message that comes out of Washington that is very clear, at least for the time being, is that programs will have to learn to live within their existing budgets.

But while the dollars are important it is not the only thing and there are some very positive things that are happening in Washington in the halls of Congress and in the Administration in regard to these. Despite the backlash, Congress and the Administration have finally begun to recognize tribal sovereignty and tribal capability to administer programs for their people, and to exercise the kinds of governmental functions that other governments, state and local, have always exercised.

I think that it is significant that tribes are no longer looked upon as just a bunch of poor little people who need a couple of pennies to help them survive. They are recognized as a viable sovereign government. We've been taught for years about tribal sovereignty and usually it's been on the defensive posture. We've used it to say, "Congress, don't give the state this power or these powers. We are a sovereign government and we are not susceptible to state control. We are a sovereign government and don't take away this power or that power and put it in some federal agency."

I think over the last couple of years you've seen a very subtle and significant change in that Congress is now perceiving tribal sovereignty as a very positive factor and they are taking steps to give tribes new mechanisms to exercise that sovereignty.

So I think the focus of many legislative workshops is on new tools, new ways that tribes can exercise their sovereign powers. It's not as much fun as going to Washington with a wheelbarrow and coming home with a barrel full of money, but for the future of the Indian people I think it's critical. It's day-to-day work. Remember what he said about getting down and rolling up your sleeves and getting down in the trenches and passing tribal ordinances, establishing enforcement mechanisms, establishing a variety of programs that take tribal sovereignty, which has been largely some kind of a theoretical concept in the past, and taking it down to the grass roots, right down to the working level, and putting it to work to make life better for you and your people and for your children.

It's going to take a lot of work but most importantly it's going to take wisdom to put tribal sovereignty to work in a day-to-day manner, hard work, sweat, in a way that makes life better for your people, particularly since there will not be more money to support that effort.

Running through the workshops you can see how this reveals itself. One workshop is on the new food stamp legislation. That legislation gives the tribes for the first time the power to administer food stamp programs for their own people. It gives the tribes the ability and power to begin to determine who is eligible to distribute food stamps. You no longer will have to count on unbending administration, federal government, state government and county government, who aren't sensitive to the unique problems of administration, or who don't care. You will be able to meet the food stamp needs of your people.

In addition, the workshop will be presented by representatives of the Indian Food and Nutrition Resource Center, which is in the process of being funded by the Community Services Administration. It will be available on an ongoing basis to provide you with technical assistance. Take this little tool and put it to work in a manner that will help your people.

Another workshop is on Public Law 93-641, the National Health Planning and Resources Development Act. In the past that's been a problem for us. Legislation has created something called Health Systems Agencies which in many cases have been trying to claim that they have the right to do the planning for Indian reservations as well as everywhere else. They represent a subtle threat not just to tribal sovereignty but to the special relationship and to the separate nature of the Indian health care system.

There is now in process, both in Congress and the Administration and probably while I'm talking Congress is acting on amendments to the health planning legislation, which specifically recognize Indian tribes as the appropriate entities to do health planning for their reservations and specifically indicate that Health Systems Agencies do not have this authority.

In addition, HEW is in the process of developing a policy which states the same principles. So, like the food stamp legislation, it's given you a tool. You now have the power to do your health planning and it's also giving you the responsibility because if you don't do that planning sooner or later the agencies will get back to you. You've been given the right, a way to enforce the tribal sovereignty and you've also been given some work to do which probably is making the process of specific health planning an annual undertaking to spell out the health needs of your reservation yearly.

Another piece of legislation that will be covered tomorrow, which takes the same principle, is the Indian Child Welfare Act. Again, it gives the tribes the power, the mechanisms, and hopefully a little bit of money to protect probably your most important resource, your children. It gives you the tools to insure that the children are not improperly taken from the reservations to adoption or foster-type programs. It gives you,

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TWO OF THE PRINCIPLE speakers at the First General Assembly exchange remarks during break in activities. NIHB General Counsel Daniel Press (left) presented legislative overview to the assembly, while IHS Director Dr. Emery Johnson was the keynote speaker at the session.

the tribal court, the tribal adoption agencies, what have you, the ability to stop this.

Again, it gives you the power. The burden is on you to put any use into it. Put it to work, develop the tools, develop the ordinances and strengthen the tribal courts so they can use this power.

Another workshop is P.L. 93-638, not a new piece of legislation but one that has been a question mark to many Indian people. One of the question marks is why is a piece of legislation that's supposed to be transferring power from one governmental entity, the federal government, to another governmental entity, the tribal entity, two sovereign entities, why is that stated in terms of procurement which forces you to use the same contract mechanisms that the government uses when it goes out and buys nuts and bolts, battleships, buildings, paper clips, what have you? I think many tribes have found its meaning accidental, while stuck with hassles with contracting offices over programs and issues.

One of the things that the panel on 638 will be covering is new mechanisms called cooperative agreements, which are designed to be agreements between two sovereign governments which reduce a lot of the burden and which clearly recognize the tribal governments are sovereign entities and are not on the same status as selling paper clips, nuts and bolts, what have you. So, again, the federal government is increasingly coming to the recognition that tribes are sovereign entities and deserve to be treated in that manner.

As well as the Congress and Administration, the courts have also taken substantial steps towards recognizing the special opportunities in the health field. The legal panel will be covering several very important decisions that have been handed down by the courts. For many years the concept of Indian health rights has been like the concepts of tribal sovereignty. It's been one of these theoretical things thrown up in the air, nobody knows what it meant.

The opinion in the case of White versus Califano has set out the responsibility of the Indian Health Service to provide care for Indians, clearly illuminating the rights Indians have to health care. The Indians have clearly established rights to health care, rights that not only are things we can talk about on the platform, but rights that the courts have enforced and intend to enforce.

Another important decision is the Rincon decision which reverses the policy of eliminating health services to the Indians of California and establishes another important principle that the federal government cannot arbitrarily cut off health services to groups of Indian people. So the courts as well as the Administration and the Congress have been moving towards a reaffirmation and strengthening of tribal rights.

The last workshop that fits in this category is the workshop on the 1980 Census. I think every tribe has been hurt by the inadequacy of the 1970 Census.

Based on complaints raised by the tribes, the Census Bureau has now initiated a major effort to make the 1980 Census a much better, more accurate one for counting Indian people. In the workshop on the 1980 Census, representatives of the Census Bureau will be describing the process they have initiated and will be asking for your assistance in helping them to insure that every Indian on your reservation is counted. It's in your best interest seeing that that happens. I think the persons involved in health, particularly the Community Health Representatives, are in a critical position to provide that assistance. The CHR on most reservations has contacted every house-

hold, knows where everybody is, knows about how many people there are in each household, and can be of invaluable service to the Census Bureau.

So if you have a sizeable tribal delegation I encourage you to send a few representatives to the 1980 Census Workshop so that you can go back home and begin to prepare for the census, which takes place next spring, to insure that every Indian is counted so that you can get every dollar you are entitled to under federal programs in the future.

That about covers the workshops on legislation. They will, I think, be an opportunity and a challenge to you.

There's a second go-round in Washington, also, this is more of a national trend that is kind of the by-product of fiscal conservatives. It's called oversight. Congress is saying we are not going to spend any more money this year, instead we are going to look into existing programs and find out what's wrong with them and find ways to improve them. I think this is important. I think if a program has a lot of problems, it is a bad program and if the problems aren't corrected, eventually it's going to hurt the Indian people because Congress is going to cut back funding and staff and we'll pay the price for bad administration whether in the service unit area or at the national level.

There'll be one workshop that will be focusing on the administrative steps Dr. Johnson talked about. 437 is now being used as kind of an oversight hearing. I intend to use it to present to Congress and to the Secretary the problems that exist inside of Indian Health Service, inside HEW and inside of legislation. That workshop will be offering an opportunity to provide input into the plan on the areas that we can change on any one of those levels. The workshop on 437 will also be talking about some of the other 437 issues that Dr. Johnson talked about; how can we work together, funding of Indian Health Service.

Probably the most important oversight activity going on is actually going to be taking place on the Senate Select Committee on Indian Affairs. I think everybody should be made aware that the Committee will be holding a hearing in Washington and others in the field to provide oversight of the Indian Health Service. It will be an opportunity for you to raise weaknesses and problems at all levels of the Indian Health Service, problems of HEW, problems in legislation that you think should be corrected. I advise you all to find out when the hearings are going to be. The dates haven't been set and the sites haven't been set but keep an eye out.

Dr. Johnson is always emphasizing that these hearings shouldn't become an opportunity just to present cases and bellyache about problems, messing around and so on. I think the hearings are an opportunity to raise issues that can be corrected through new policies, new legislation, new structures in staff and so on, rather than particular problems with particular individuals.

I think that in turn imposes a special obligation on Indian Health Service. They have to set out an effective grievance mechanism inside Indian Health Service so that if you have a problem you have a place to bring it and are insured that it will be resolved quickly and fairly. I don't think that exists in most places in the Indian Health Service. I think various health boards have tried to do it and have been tremendously frustrated. They raise differences with the service unit director, the area director and headquarters and find out that they're brushed aside and that really doesn't deal with the problem.

The last workshop that I'll be covering I think represents one of the most exciting developments inside the Indian community development area. The Alaska Native Health Board has entered into an historical memorandum of agreement with the Indian Health Service which could involve a more effective grievance mechanism within IHS. It spells out responsibilities to the different parties along with time limits in which IHS has to respond to grievances of the health board and it sets out an appeal mechanism if you are dissatisfied with the decision you get out of the local area level.

The workshop on area health boards will be moderated and facilitated by representatives of the National Indian Health Board who will be describing to you this important new system that has been established.

That covers the workshops on legislation and basically, what's happening in Washington. The important things are sovereignty and oversight.

In summary, the lack of money, the lack of new funding is going to be a serious problem. I think that all the programs in the government, the Indian Health Service is one, their lack of money will be a serious impediment to substantial improvement. We have two choices, we can sit around and cry over the lack of money or we can say, "This is the way it is and let's get on with these other new tools that Congress is giving us. Let's use the materials made available to build our tribal institutions, to put to work our sovereign powers, to improve the Indian Health Service, the HEW health systems, make them work better for us."

I was looking through the schedule and I noticed the enormous wealth of talent that is available in those workshops. You have the Indian Food and Nutrition Resource Center, you have the Native American Rights Fund, the Alaska Native Health Board, the National Health Insurance program staff, NCAI attorneys, just a very impressive wealth of resources.

For them and most of the people in Washington I guess I conclude with the statement that they will give you information and knowledge but I leave you to the challenge of taking it back

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PORTLAND NIHB REPRESENTATIVE Mel Sampson responds to question during July 23 press conference. Sampson stated that "Indians are no longer pacified or satis-fied with what's given to them if it is not adequate. Health services are just as important to the tribes as treaty and water rights."

home and having the wisdom to put it to work to produce a vision of better health for your people.

HOWARD TOMMIE: I'd like to introduce William Wilson, Executive Director of the Association of American Indian Physicians.

BILL WILSON: We're going to be talking this afternoon in a workshop called Indian Health Manpower Development.

In most instances when we talk about this, we program and Indian health tribal development people, we sit down and talk with each other, tell each other our problems. This year we're taking a new twist. We've discussed this with a number of programs nationally in different areas, you might have one in your area, and we've decided that the problem that we have is very simple: we're not getting enough trained Indian people. As I sat here this morning listening, we talked about different programs, we're always interested in getting funding, we want the money, but it seems to me that we're overlooking one of the most important resources that we have and that's our children.

Indian people, when you look around in most areas, don't have a lot of resources. I think the most important resource that we have is our children. We have children that we're bringing up and hopefully training, educating, this is what we're dealing with now.

The association is working primarily for effective schools. The problem we are having in competing for slots, we have maybe one or two Indian people come in and compete for slots when we should be having 10 or 20. So what we're looking for, I'd rather see a hundred apply and maybe only ten per cent get it, but, at least, we've got 10 in.

So what we're going to be talking about in the Health Manpower Workshop today is health career backup. We've got Indian people that will be presenting the different parts of the workshop. We're going to track the student all the way up to professional school, and what I'm interested in are those people, primarily parents, and those people that work with tribal programs, business managers, et cetera.

Many of you are interested, of course, in the other workshops and they're very important, but for once I'm inviting you not to go to the workshop that you have come to attend, come to our workshop, Health Manpower Development, because this is going to be something that I think, again, is very important.

We are going to talk in terms of how you can keep the child in school from grades 10 through 12. We'll be talking at the undergraduate level, college, what resources are available there trying to keep the student in school. Then we'll go into professional schools, how you get in.

So I'm inviting you all to come and attend the Manpower Workshop if you are interested in keeping your students in school. There are some of you probably that will go to other workshops, you know, people that aren't really interested in anything, but, those of you that have superior intelligence come to my workshop.

HOWARD TOMMIE: That gives us a pretty good clarification of what most of our workshops are and what this conference is going to be, specifically from the board and all the people that are in the conference as well as the people that are working to accomplish the goal of getting the Indian constituents to better understand some of the policies and laws as well as the programs.

Again, I want to thank everyone that has joined here for this conference on behalf of the National Indian Health Board. I want to thank everybody for getting up early and joining us this morning.

At this time we'll recess until the workshops start at 1:00 p.m.

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Legislation Workshops

NATIONAL HEALTH INSURANCE/NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974 (P.L. 93-641)

Moderator: Billy Kane, NIHB Representative, Phoenix area

Facilitators: Howard Bad Hand, NIHB Program Analyst
Daniel Press, NIHB General Counsel

The major focus of the workshop was on the efforts of the NIHB NHI/641 Core Group to get HEW and the Congress to establish the principle that Health Systems Agencies (HSAs) created by P.L. 93-641 do not have any authority to plan for Indian reservations and that Indian tribes have the primary responsibility for health planning and implementation on their reservations. This effort is proceeding on two fronts.

First, the Core Group has spent the past year negotiating with HEW over a policy statement that would set out the limitations of HSA authority vis-a-vis tribes on health planning, limitations on the HSA role in review and comment on proposals submitted by tribes, and the need to sensitize urban HSAs to the reasons urban Indian health programs were established, so they will not consider such programs duplicative when called upon to exercise their review and approval authority over proposals being submitted to HEW by urban Indian health programs.

While the basic principles of the policy have been agreed to, the policy paper has gotten hung up in the Office of the HEW General Counsel. The General Counsel accepted the basic principles, but he had some problems with some of the phraseology in the paper developed jointly by the Core Group, IHS and the Bureau of Health Planning. At conference time, it was expected that a policy paper would be promulgated within the next month or so.

The second front is an effort to get Congress to adopt amendments to P.L. 93-641 recognizing the special status of Indian tribes and establishing the principle that, in dealing with tribes, HSAs must act in a manner consistent with Indian self-determination. The legislation has passed the Senate and the House. However, because there are differences in the language adopted by the two congressional bodies the matter must go to a conference committee. It was expected that appropriate language, in the form of amendments, would be adopted by the Congress by the end of September. *(Editor's Note: This language has since been adopted.)*

The principles in the HEW policy statement and the congressional amendments are basically the same. First, it is made clear by the Congress and HEW that tribes could not be completely exempted from the 641 process. Congress took the position that every inch of an HSA must be planned for and discussed in the Health Systems Plan (HSP). Therefore, the challenge was to find a way to have tribes included in this process in a manner that enables them to protect and exercise their sovereignty and self-determination. Based on that effort, both Congress and HEW will come out with a principle that tribes have the primary right and responsibility to plan for the health needs of their reservations. This could take a number of different forms.

In the best of all possible worlds, tribes and HSAs will be able to cooperate in health planning, developing a joint plan and discussing ways to improve health services in those areas where the Indian and non-Indian health systems come into contact. However, where, because of hostility between a tribe and an HSA, this is not possible, a tribe will have the right to say that it alone will do the health planning for its reservation and that its Tribal Specific Health Plan must be incorporated intact into the Health Systems Plan. This means that the tribe will have the ultimate right to develop and implement the planning for its reservation. It is up to the tribe to decide what level of cooperation or noncooperation it wishes to have with an HSA, though the bottom line is that the tribal plan must be incorporated into the Health Systems Plan; the health needs of the reservation cannot be completely ignored in the Health Systems Plan.

The second principle addresses problems in the review and comment area. First, HEW will instruct all of its regional offices and the HSAs that HSA authority in regard to tribal proposals is limited to review and comment and that an HSA shall not use terms indicating approval or disapproval. Also, before an HSA can comment that a tribal program is duplicative of services avail-able in the non-Indian community, it must be able to demonstrate that the services in the non-Indian community are available and accessible to Indians

and are provided in a manner sensitive to the unique needs of Indian people. For urban programs, HSAs will be instructed to be aware of the unique status of urban Indian health programs and to not view them as duplicative where Indians have found the non-Indian system insensitive to their needs.

Lastly, recognizing that several parts of Indian country represent unique situations, the principles indicate that the tribes and the HEW regional offices in Oklahoma, California, Navajo, and Alaska are to modify the principles in such a manner as is necessary in order to make them appropriate to their particular situations.

Once the congressional legislation and the HEW policy are adopted, (expectedly by the end of September), tribes will no longer have to worry about HSAs usurping tribal powers or authorities. On the other hand, tribes will assume several responsibilities. If they want to be the entities responsible for health planning on their reservations, they will have to be responsible for developing an annual health plan. (This can involve an annual updating of their Tribal Specific Health Plan). Tribes will also be encouraged to work cooperatively with HSAs to improve coordination between the Indian and non-Indian health systems. Tribes wishing assistance in developing cooperative relationships with their HSAs, or having problems with HSAs that refuse to comply with these principles can call upon NIHB, IHS and the Bureau of Health Planning for technical assistance.

With regard to National Health Insurance, Howard Bad Hand spoke of the Administration and Kennedy NHI plans and their implications for Indians. Under the President's proposed plan, all Americans would have access to health care either through their place of work or through the federal government, with the government taking responsibility for the poor, part-time workers, aged, disabled and unemployed. Low income people would have no cost sharing obligations. This means that about half the Indian population would receive free medical care. In instances where IHS funds are used, IHS would have to obtain reimbursement from the NHI plan sources. As now written, the Carter plan would put an extra burden on tribes causing them to pay for their employees coverage. The President, however, appears to be agreeable to consideration of subsidizing the tribes.

Senator Kennedy's plan is similar in that participants could be enrolled in one of two ways. Employers would be required to offer all employees health insurance, with premiums based on the employee's wage and an employee required to pay up to 35 percent of the premium. Therefore, employed Indians would be required to pay some premium though it may be subsidized. Welfare recipients would have their premiums paid by the state welfare department. IHS could again be reimbursed by the proposed NHI program, with the program setting a prospective budget for IHS facilities based on projected utilization.

INDIAN HEALTH MANPOWER DEVELOPMENT

Moderator: Dr. Marlene Haffner, Director, Navajo Area Indian Health Service

Facilitator: William Wilson, Director, Association of American Indian Physicians

Panel Members: Dick Spinning, Director, Hopi Health Professions Development Program
Lydia Pourier, M.P.H., Consultant
Bernard Kahrahrah, Director, INMED

The purpose of this workshop was to give information to parents and others interested on helping Indian students to select and pursue "health career pathways."

Wilson gave an overview of the need for "health careers pathways" for Indian youth to ultimately prepare them for college entrance exams. He stressed that communications and math were the two most important skills to develop in grades K-12 and that science skills, though important, could be picked up later.

Spinning stated that a prime objective is that of keeping Indian students in school and interested, adding that such encouragement must begin at an early age. He covered grades K-12 by emphasizing what parents could do to overcome the barriers of negative attitudes being developed towards school and the health professions. He stressed that parents should be especially supportive of children to maintain positive attitudes toward themselves in the face of negative peer pressure related to the choice of math and science courses.

He also suggested that parents become actively involved with local school boards to assure that (a) the curriculum is relevant to the Indian community, (b) field trips are available to give exposure to health career role models, (c) self-concept development activities are included in the curriculum, and (d) that sex and drug education are available in the school. Also, parents should see that work experience in health fields is available to students.

Pourier discussed the undergraduate college level. She stressed the importance of the family unit in reinforcing the individual strengths of the Indian student in order to break out of their familiar circle to attend college. She utilized a

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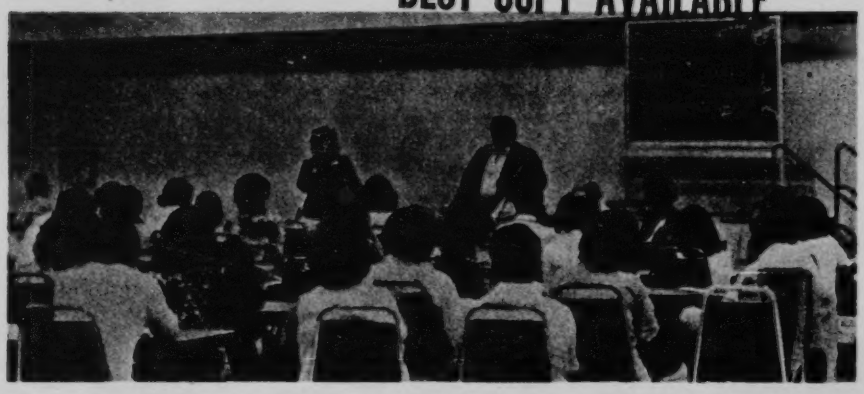


HEALTH PROFESSIONS EDUCATION was one of the main topics of discussion at the workshop on Indian Health Manpower Development. Panel Member Lydia Pourier (standing, left) addresses group as workshop moderator William Wilson (standing, right) listens.

model for development of four strengths:

a) "inter-student strengths" — it is cruel to send students to a place where they will be alone. We should attempt to "cluster" Indian students at colleges which welcome them.

b) "inter-family strengths"

c) "inter-community strengths" — show the student you are proud of them as someone who will be coming back to work as a health professional in the Indian community.

d) "inter-professional strengths" — expose the student to Indian health professional groups and meetings so they will have good role models.

Parents should also deal with "the outer circle" (the college and the faculty) by visiting the student at college to help break down loneliness and by meeting college faculty.

Kahrahrah discussed professional schools. He stressed that "a commitment to people" was the basic requirement. A "self inventory" is then needed to persist in school (i.e., Do I have the confidence in my abilities? Do I have the resources? Who can help me?).

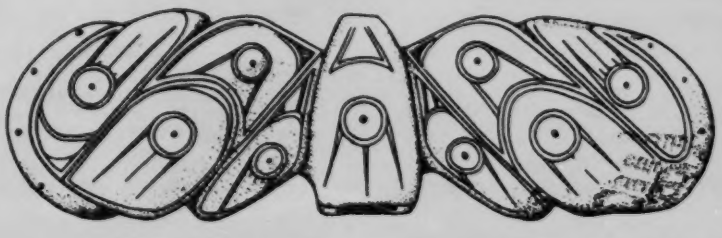
Choice of a professional school depends on the following: geographic location, private or public, curriculum, support services offered, Indian Studies program, availability of housing, and transportation.

In making an application, forms must be completed and sent in by the established deadlines. Standardized tests, such as the MCAT, must be taken. An interview follows these initial steps. If the student fails the admissions tests, he/she should have alternative career plans (e.g. medical technician, laboratory technician, community health medic).

Resources for professional schools include those offered under Section 103 of P.L. 94-437. The BIA and OIE have listed five priority fields for educational funding: medicine, business, law, forestry, and natural resources.

Spinning continued with a discussion of tribal health programs, which might also be utilized towards health career preparatory training. He stressed that the key is to look at the resources currently available. Among these are: a) JOM and CETA offered through the Department of Labor, which are very versatile. They allow junior high and high school students early exposure and training in health careers. They provide motivation and good health delivery programs for role modeling. b) Title IV allows students at the elementary level to learn about health careers.

The workshop adjourned with a resolution urging an amendment to the Indian Health Care Improvement Act in additional support of Indian health manpower development.



TRIBAL SPECIFIC HEALTH PLANS AND THE IMPLEMENTATION OF THE HEALTH SERVICES AND CENTERS AMENDMENTS OF 1978 (P.L. 95-626)

Moderator: Lawrence Snake, NIHB Representative, Oklahoma area

Facilitator: Jack Casebolt, Director, IHS Office of Program Planning

Panel Members: Robert Birch, D.D.S., IHS P.L. 94-437 Project Manager
Rick Nordwall, NIHB Program Analyst

After introductory remarks by Lawrence Snake, the workshop proceeded with remarks from Jack Casebolt. He gave a description of P.L. 94-437, which he said was passed to implement federal responsibility of the care and education of Indian people by providing them services, facilities, and health programs. The law also provides for the maximum participation of Indian people.

This latter provision is one of the important reasons for Tribal Specific Health Plans (TSHP) that have just been completed by almost all of the tribes in the United States. Over 100,000 hours and 2½ years have been spent trying to identify health specific needs of Indians.

One major problem encountered by tribes in the development of these plans relates to the population figures used by tribes and those used by the federal government. Many of the tribes have actual head counts of their populations, and the government uses 1970 Census Bureau figures that have been projected through 1984. Many tribes feel these latter figures are not accurate. In an attempt to address this problem, the TSHP guidelines stated that Census Bureau figures should be used, but allowed for a second set of calculations based on tribal population counts to be used in the plans.

Mr. Casebolt also addressed the report required by P.L. 95-626, which is supposed to describe the access and barriers to health care faced by Native Americans. NIHB will be allowed to submit its recommendations as an amendment to the report. The urgency of the P.L. 95-626 report is that it will be used for the FY 1980 appropriations process.

Mr. Snake then introduced Rick Nordwall of NIHB who is preparing the report that will be submitted by NIHB for inclusion with P.L. 95-626 report to Congress. Mr. Nordwall emphasized the low appropriation levels that Congress allows for laws like P.L. 94-437 and that tribes should be allowed to administer funds from the federal government directly.

He read excerpts from his paper highlighting problems such as the Medicaid problems in Montana and North Dakota, the reluctance of tribes to contract under P.L. 93-638, and the shortage of funds to IHS. This reduces the services that IHS can provide to Indian people because of inadequate facilities, equipment, and staffing.

Dr. Robert Birch was then introduced, and he stated that what was being done at the TSHP workshop related well to the workshop that he was conducting tomorrow on recommended changes and/or additions to improve P.L. 94-437. Dr. Birch said that instead of taking time away from this workshop he would rather spend the remaining time answering questions from the audience.

Herbert Smith, pharmacist from California, asked which population figures will IHS use to approach Congress for funding, tribal or Bureau of Census. Mr. Casebolt replied that there is a law that mandates Congress to use the Census Bureau figures, but he added that TSHP's could reflect calculations by tribes if there was a discrepancy between the two figures.

Barbara England, California, asked about the format to be used for the plan submitted to the Secretary; what information will be held in it and will there be any tribal involvement? Mr. Casebolt responded that because of other agencies involved in the process the format would be difficult to ascertain, but that the report would list specific needs of each tribe benefits that they would receive under P.L. 94-437. The number of tribes that have definite health deficiencies would be identified.

A man who identified himself as a health planner from Oregon asked whether IHS would give assurances that the information submitted in the TSHP's will be used and in what time frame. Mr. Casebolt replied that this process is ongoing and it changes all the time, so no one can assure that each tribe will receive everything they requested. But, he said, IHS is not going to throw away 2½ years of work, and that if tribes continue to work through the service units and areas they will be able to utilize their TSHP's as they hope to. A gentleman from the audience added that tribes already have the tools and techniques to utilize the TSHP's and if there is good documentation they can proceed with them now.

Clyde Sanchez, New Mexico, expressed his concern that TSHP's would be buried under by other plans and that Health Systems Agencies could use the information contained in them for their own benefit. He also stated that since IHS is developing its own plan it would bury the TSHP's deeper. Some way should be developed to put the TSHP's on top and not on the bottom. Dr. Birch responded late in the program that he hoped that

something like this wouldn't happen, and although there was a possibility it is very unlikely that it will.

Other comments were made by people concerning census figures and assurances and Dr. Birch responded that everything that is justified in the TSHP's will be utilized in the national plan for presentation to Congress because IHS is committed to support American Indians and Alaska Natives in every way they can.

A number of recommendations resulted from the group discussion. Among others, these include:

- inclusion of patient care rights in next year's Tribal Specific Health Plans
- increased tribal involvement with national TSHP activities rather than working heavily through national organizations
- utilization of tribal population figures, instead of those of the U.S. Census, in planning under P.L. 94-437
- extension of eligibility under federal health legislation to state-recognized tribes
- involvement of the national Indian consultants group with finalization of the format of the P.L. 94-437 National Plan under preparation by IHS.

CONTRACTS, GRANTS AND INTERGOVERNMENTAL PERSONNEL ASSIGNMENTS

Moderator: Elwood Saganey, NIHB Representive, Navajo area

Facilitators: James Danielson, Director, IHS Office of Program Support
Paul Dickerson, IHS Contract Officer
Art Hill, Cheyenne/Arapahoe, Oklahoma City, Oklahoma
Jim Sharlow, Health Services Administration, Rockville, Maryland
Raleigh Nielson, Aberdeen Area Indian Health Service

James Danielson outlined two very large related subjects: contracting and related subjects and Intergovernmental Personnel Assignments. One is a method for tribes to operate programs, the other a way to increase staff.

Paul Dickerson reported on two pieces of legislation, one being P.L. 95-224, the Cooperative Agreement Act which will allow a new type of contract process between federal and local governments. IHS guidelines will be unique for providing cooperative agreements between IHS and Indian tribes, and will not be the same guidelines used by other HEW programs.

Secondly, Dickerson spoke of the Joint Simplification Act, which allows a single document for more than one federal agency entering into agreements with a local government.

Art Hill reported on the joint funding program being administered by the Oklahoma Cheyenne Tribe. He said the program is working well overall and touched on the following advantages:

- a single letter of credit
- one annual report with quarterly and monthly reports on an option or waiver
- one audit
- one lead agency responsible with one project officer
- one calendar year for all programs
- forces tribes to do comprehensive planning

Dickerson touched on letters of credit. At present, the BIA is using the process of letters of credit with its 638 tribal programs. DHEW plans to begin using the Departmental Federal Assistance Financing System (DFAFS) which is in effect the same process. There are two methods of reimbursement under the DFAF system: monthly treasury checks or letter of credit operated through a local federal reserve bank.

In the past, IHS has used the advance payment method but will now begin using letters of credit. A policies and procedures manual for recipients of the letter of credit will be distributed soon. This new method should begin with the start of the new fiscal year, but is not mandatory.

In order for an organization to qualify for a letter of credit it must meet the following requirements:

- must plan to have a continuing relationship with the department for at least one year
- must have total funding of at least $120,000/year
- must have an effective management system for control of federal monies

Jim Sharlow and Raleigh Nielson gave a presentation on Intergovernmental Personnel Assignments under the Inter-Governmental Personnel Act in effect since 1970.

Some of the questions and answers posed following this presentation were as follows:

1. How does this affect the overall IHS staff position ceiling?

   The ceiling does not change as long as the employe is detailed or IHS continues to pay more than 51 per cent of his/her salary.

2. Does a commissioned officer or civil service person remain an employe of the

government when he or she is under an IPA agreement to a tribe?

Yes, the person always remains a government employe unless they choose to resign and work solely for the tribe.

3. Are IPAs only for 638 contracts?

No, IPAs can be done with a number of federal agencies and even state agencies.

Danielson addressed the advantages of IPAs. He included the good training and orientation supplied by the IPA personnel, and how local projects can assume control. It is also possible to negotiate for some of the personnel after the original length of their assignment is over.

He suggested use of the Cooperative Agreement Act, the Joint Funding Simplification Act, and the Intergovernmental Personnel Assignment Act to receive increased funding. Danielson stated that they can be used to advantage as alternate means of support for tribes and Indian health boards if done in a creative fashion.

STATUS OF AREA INDIAN HEALTH BOARDS

Moderator: John Belindo, NIHB Executive Director

Facilitator: Ethel Gonzales, NIHB Representative, Alaska area

Co-Facilitator: Ronald A. Hodge, Attorney

This workshop stressed the strengthening and development of area and local Indian health boards through a number of recommended means.

One of these would be the provision of a comprehensive board training program to be developed by the National Indian Health Board (NIHB). NIHB would provide training in the areas of health care planning, staff and personnel relations, Indian law and the application to federal systems, the legislative and budgetary processes and other elements involved in the federal health care system. Further, area boards would be provided with technical assistance in locating attorneys and other advisors to assist in their development.

Workshop participants recommended that federal contracting and procurement systems should be analyzed in depth to determine the most efficient and expeditious manner of contracting with Indian tribes and native groups, e.g., in areas such as cost reimbursement, contracting vs. fixed price contracts, cooperative agreements and other related procurement matters. Further, it was recommended that specific sections in the contract documents themselves should be analyzed concerning key personnel, advance payment, subcontracting opportunities and travel with a view towards limiting involvement of the contracting officer. In addition, participants recommended that an analysis of actual negotiating sessions should be undertaken to determine whether they are bilateral with Indian participation or unilateral with only the contracting officer speaking.

Cost benefit analysis should be undertaken by NIHB or some other recognized national entity, to determine whether area IHS offices and the headquarters office are utilizing congressional monies in an effective, efficient manner, recommended participants.

It was next recommended that IHS implementation of the Indian Self-Determination Act be reviewed based on a request of Native and Indian groups.

And further, that area boards should look into the feasibility of establishing themselves as non-profit corporations under the state laws or Indian legislation under which they operate.

This workshop also recognized the need for an expanded view to analyze and review Indian cultural communicative patterns, perhaps including research into intuition, cultural empathy and other positive aspects of Indian culture.

Another major area dealt with was review and development of proposals for health care alternatives. The possibility of establishing a Health Maintenance Organization as a more meaningful third party payment system and the possibility of developing a National Indian Health Insurance corporation were discussed.

The next major area discussed was developing capital alternatives, such as foundations or Indian tribes with an abundance of natural resources and capital, to assist in development of a new Indian health care system providing Indian people with the element of choice.

In summary, it was recommended that NIHB must assert a more definitive goal-oriented direction to assist area boards, to provide training and to establish health care alternatives for the betterment of Indian and native peoples.

TRADITIONAL INDIAN MEDICINE

Moderator: Jack Jackson, Councilman, Navajo Tribe

Facilitator: Edward Tso, Director, Office of Native Healing Science, Navajo Health Authority

Panel Members: Alex Boone, Zuni Tribe
Stanley Red Bird, Chairman, Rosebud Medicine Men and Associates
Isadore Tom, Lummi Tribal Spiritual Leader

An employee feels sick. Trusting the traditional methods of healing, he visits the tribal medicine man.

But the health insurance that is part of his work benefits won't cover costs of such "unorthodox" medicine. Participants of this workshop proposed a change in that policy because it discriminates against native people.

"Everyone should know about the Native American Religious Freedom Act because, although it concerns religion, it is a part of the culture that concerns everything, including medicine," said Jack Jackson, who serves on the national advisory board for the law.

"We're not here to question the validity of traditional Indian medicine — it's already there," Jackson told the capacity crowd attending the workshop. "We have to utilize native healing ways as an alternative to combat the deplorable health problems we have today — especially mental health and alcoholism."

But in case there was any doubt, workshop participants offered testimony to the effectiveness of traditional medicine.

Stanley Red Bird, Chairman of the Rosebud Medicine Men and Associates in South Dakota, talked of the problems of alcohol and drugs in Indian populations and blamed the move away from breast feeding for problems with Indian youth.

"Medicine men have proven themselves — they have 25 to 40 years experience, much more than the seven years it takes a white man to get a degree as a doctor," he said.

"We all came from a seed. We are another plant and are related to all the other plants on this world," Red Bird said.

His tribute to nature's ways was seconded by Isadore Tom, a spiritual leader from the Lummi Tribe near Bellingham, Wash.

Medicine people receive the gift of medicine. They have a vision of what to do that is a part of nature, Tom said.

"In times when there were no doctors, hospitals, pharmacies, Indians lived by nature and survived hundreds of years before the white people came," said the man who considers himself "more of a spiritual than medicine man."

He recalled working with the Western medical tradition, lecturing medicine students at the University of British Columbia and helping Northwest physicians when established medicine failed in combatting illness.

Tom's cooperation with established, modern medicine was one focus of a resolution proposed by Edward Tso, facilitator of the workshop and director of the Office of Native Healing Science for the Navajo Health Authority.

The resolution he proposed submitting for National Indian Health Board consideration noted that traditional Indian religion is key to the culture and inseparable from traditional medicine. It further stated that Indian people have a right to be healthy and happy.

The resolution suggests that:

- Traditional medicine be recognized as a health system for Indian people.
- The formation of medicine men associations be encouraged.
- Federal departments and agencies cooperate with traditional medicine associations.
- Funds be made available to preserve and promote native healing practices.
- Methods of blending traditional and modern forms of medicine be researched.

Jackson suggested traditional medicine be recognized by the Indian Health Service and tribal councils as part of overall health care systems, and that medicine men be certified and scholarships be offered to young people to study the healing methods.

WORKSHOP FACILITATOR Edward Tso (at podium), Director of the Office of Native Healing Science, Navajo Health Authority, takes note as Traditional Indian Medicine workshop panel members listen to comments from audience.

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INDIAN PROVISIONS OF THE FOOD STAMP ACT OF 1977

Moderator: Timm Williams, NIHB Representative, California area

Facilitator: Bob Price, Director, Commodity Food Program, Papago Tribe

Co-Facilitator: Rick Hart, Attorney, Food Research and Action Center

In 1977, Congress passed, as part of the Food Stamp Act, specific Indian provisions dealing with commodities and food stamps on Indian reservations, that for the first time, begin to address Indian/Alaska Native food needs. This workshop dealt primarily with how tribes can now take advantage of the new legislation.

As presented by Price and Hart, participants of this workshop were informed that:

Just a few years ago, Indian people began making great strides in many areas such as education, health issues, and economic enterprise; but one area generally overlooked was that of food and nutrition and especially food. However, as Indian people gained advances in other critical areas, they began to look around with more experienced eyes and noted the food and nutrition deficiencies. As evidence of this, in Senate Select Committee hearings several years ago, there were only a handful of tribes who submitted testimony, while in the U.S. Department of Agriculture (USDA) workshop in 1977, there were hundreds of Indian and Alaska Native representatives.

One of the most important results of this 1977 workshop was the beginning of a combined, national effort by Indians and Alaska Natives to impact upon the area of food and nutrition and especially upon those programs administered by USDA: the Food Stamp and Commodity Food Programs.

As a result of the cohesiveness on food and nutrition issues, hundreds of Indian and Alaska Native delegates supported and passed a formal resolution at the NCAI convention in Dallas, Texas creating and selecting area representatives to what is now the National Indian Food and Nutrition Resource Center (NIFNRC).

Based upon recommendations of Indian representatives at the Albuquerque meeting, an intensive lobbying effort was undertaken by Indian/Alaska Native people and others resulting in the Indian Provision Amendments to the Food Stamp Act of 1977. There were several major provisions in these amendments, some of which are:

- any tribe requesting a commodity program can have one
- Tribal administration of the commodity program
- Improvements to the commodity package
- Concurrent operation of commodities and food stamps on an Indian reservation
- Consultation with Indian people required by a state operating either program on an Indian reservation
- Tribal administration of food stamps, if a tribe is capable and if the state has major deficiencies in its obligations of efficiently and effectively administering the program on an Indian reservation.

Two years after the new act was signed into law, USDA has published final regulations on the Indian provisions. These can be found in Volume 44 of the Federal Register pp. 35904-943 published June 19, 1979. Copies of these regulations can be obtained from local USDA regional offices. They are of immediate concern to all Indians and Alaska Natives and require immediate action on their part to gain the best and most timely benefits for their people. In order to gain benefits, tribes must submit their formal requests to the appropriate regional office of USDA immediately.

Provisions for administration and benefits received differ under each program. Before getting into the individual aspects of each, a tribe must make some general, overall decisions. First of all, does it wish to receive benefits from both the commodity food program and food stamp program or just one of them? If it decides to participate in the commodity program only, no Indian on that reservation will be able to get food stamps. However, if a tribe opts for concurrent operation of both programs, households otherwise eligible will be able to choose either program or even switch back and forth as they desire or as is necessary. Several tribes including Navajo, Papago, and Nez Perce are participating in a concurrent operation and find their situation to be a good one.

Dealing specifically with the commodity program, in order to receive benefits under the program, a tribe or inter-tribal organization must submit a written request to the regional administrator of USDA. If several tribes decide to operate a program jointly or to have an inter-tribal organization operate it for them, formal resolutions from each tribe authorizing this must accompany the request. In order for a request to be considered by USDA it must have all of the information USDA deems necessary to reach a determination on a tribe's capability to administer the program. It appears that each region has a certain amount of latitude and the information required may vary by region. However, if a tribal request lacks any of the necessary information, USDA is required to inform you of the specific items lacking.

Participants were advised to note that the initial request must come from the tribes; USDA is not required to make any efforts until a tribe makes a formal request. Once USDA has a

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ROBERT PRICE (standing), Chairman of the National Indian Food and nutrition Resource Center Board, discusses food programs during workshop on Indian Provisions of the Food Stamp Act of 1977. NIHB California Representative Timm Williams (left) served as moderator for the workshop, and Rick Hart (right), Attorney for the Food Research and Action Center, was co-facilitator.

request, with all of the necessary information, it has 60 days to determine the administrative capability of a tribe.

If the USDA deems a tribe or inter-tribal organization capable of administering the program, it must begin negotiating a "plan of operation" and level of administrative funding (the basic amount is 75 per cent federal, 25 per cent matching) and provide any training and technical assistance necessary.

If USDA deems a tribe or inter-tribal organization incapable, even if it provides training and technical assistance, then the state is required to operate the program on the Indian reservation. The state also negotiates the plan of operation, the level of administrative funding and whatever training and technical assistance is necessary.

While there is also provision for tribal administration of the food stamp program, the prime emphasis is on causing state-operated programs to be responsive to Indian needs and desires with tribal administration a last resort.

The law and the regulations provide that a state operating a food stamp program on an Indian reservation shall consult in good faith with the tribe in developing its plan of operation, maintain ongoing consultation, and allow the tribe 30 days to review and comment before submitting the plan to USDA. Then, the tribe's comments must accompany the plan.

Once the state is operating the program, USDA assumes everything is operating smoothly unless it receives a tribal complaint. Such a complaint will be initially evaluated solely on the basis of content. Without looking at anything else, someone in USDA will read the complaint and decide if it has merit. Therefore, any complaint by a tribe must be well-documented and show state failure. After USDA decides a complaint has merit, it will begin an investigation to determine if there actually is state failure and if so, to what degree. Regulations require USDA to complete its investigation and render a decision on state failure within 90 days. Once a "judgment" is found against a state, the state has 30 days to either correct the failure or submit a corrective action plan to USDA with copies to the tribe. If the state does neither, then a finding is rendered against the state and the tribe is allowed to administer the program if USDA determines it is capable. However, if the state chooses to submit a corrective action plan, it has an unspecified amount of time in which to carry the plan to fruition.

Once USDA decides to allow a tribe to administer the program, then begin negotiations on the plan of action and level of funding (basic 75 per cent federal funds and 25 per cent match) and the provisions of training and technical assistance.

In summary, in order for anything to occur under the Food Stamp Act of 1977 and federal regulations, Indian tribes and Alaska Native groups must submit a formal application or complaint to an appropriate regional USDA office. If these applications/complaints are judged to be sufficient or have merit, then begins a countdown until the time the tribes will gain tangible results and benefits. In the event a tribe is requesting a commodity program, the earliest possible starting date would be five months from the time of the request; if it is a food stamp complaint, the earliest possible results in correcting the deficiencies or finding out if a tribe would be allowed to administer the program would be four months. It would take another four months for transition from state operation to tribal administration.

In view of the fact this legislation was enacted almost two years ago and the time periods involved, it is in the best interest of the Indian and Alaska Native people to initiate formal requests and complaints to the appropriate regional offices of USDA at the earliest date possible.

1980 CENSUS

Moderator: Richard Medina, National Services Program Specialist, U.S. Bureau of the Census

Facilitators: Marion Wolff, Program Analyst, U.S. Bureau of the Census
Alice Solomon, Community Services Specialist,
U.S. Bureau of the Census, Seattle, Wash.

This workshop focused on the importance of next year's census for Indian communities nationwide. Richard Medina, National Services Program Specialist, told participants that they need the 1980 Census if their communities need: job training and employment; adequate low cost housing; better schools and playgrounds; health care services; day care services; adult education programs; parks and recreation services; legal services; emergency food and medical aid; special services for senior citizens, or other facilities provided through community action programs.

He cited a number of examples of how census data aid directly in the distribution of federal funds:

- The total population and per capita income statistics for 39,000 local governments help the Treasury Department's Office of Revenue Sharing distribute funds under the State and Local Fiscal Assistance Act.
- The number of people, 18 and older, who have less than five years of schooling, determines the amount of money allotted to each state under the Adult Education Act.
- The number of children, 5 to 17, in poor families, determines the amount of money allotted to counties under the Elementary and Secondary School Act.
- The number of children in non-English-speaking homes also determines distribution of other funds under that act.
- The number of people unemployed, or with low incomes, determines whether a community qualifies for assistance under the Public Works and Economic Development Act.
- Based partly on census information, federal funds are distributed under: The Public Health Service Act, The National School Lunch Act, The Economic Opportunity Act, The Manpower Development and Training Act, The Vocational Education Act, The Higher Education Facilities Act, The Federal Aid to Highways Act, the National Housing Act, The Housing and Urban Development Act, and The Appalachian Regional Development Act.

In addition, the Census Bureau carries out special tasks for other federal agencies on a reimbursable basis. During Fiscal Year 1977, approximately $60 million was spent through the Census Bureau by: the Veterans Administration, National Science Foundation and the Departments of Treasury, Agriculture, Defense, Commerce, Energy, Transportation, State, Housing and Urban Development, Justice, Labor, and Health, Education and Welfare.

Census data is used for the distribution of "federal funds" to state and local governments, such as Indian tribes. This amount is estimated at more than $50 billion a year, with additional billions of dollars in state funds.

The next census begins April 1, 1980. Following this count, the census will be taken every five years, rather than once every decade as in the past.

Census questionnaires will be mailed to each household with about 90 per cent of the population asked to mail back the completed questionnaires. Those households which do not return a questionnaire by mail will be visited by a census enumerator who will obtain the required information. The remaining 10 per cent, primarily those in sparsely settled areas, will be asked to hold the forms for a census taker to pick up. A special supplemental questionnaire has been designed for use on Indian reservations.

About 22 per cent of all households will receive a long form questionnaire in 1980 with the remaining 78 per cent receiving a short form. The long form requires about 45 minutes to complete and the latter about 15 minutes.

Alice Solomon, Community Services Specialist from Seattle, Wash. stated that more assistance in tutoring and preparation will be done for Indian enumerators by hers and other census agencies as requested. To improve the count of minorities, the bureau is establishing a corps of "community services specialists" to work closely with minority community groups and leaders in explaining the importance of the census and to gain minority organization support. The Census Bureau also has established citizen advisory committees, or local review committees composed of minorities, to advise on efforts to improve the count of minority groups.

Solomon stated that many Indian tribes were overlooked or underfunded, because of the 1970 census which counted only 115 tribes, or only one third of all Indians and Alaska Natives.

Marion Wolff, program analyst with the Census Bureau, stated that leaders of the American Indian population are providing, through periodic regional and tribal meetings with bureau representatives, ideas and suggestions for counting their individual populations in

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1980. It was also mentioned that tribal planners should be involved; rather than tribal chairmen only, when comprising local review committees.

Workshop participants adopted a resolution with the intent of making the Census Bureau aware that it does not have an Indian advisory board. If established, such a board could offer greater familiarity with tribes and groups of Indians and Alaska Natives that should be counted.

Presently, many Indian people are excluded from the category of Native Americans during the census. A good example, California Native Americans are being shortchanged because the only Native Americans that are counted are members of established reservations or rancherias. Consequently, many Indian people are overlooked.

PARTICIPANTS AT THE workshop on the 1980 Census heard about the many federal programs that utilize Bureau of Census figures in delivering services to communities throughout the country.

LEGAL DEVELOPMENTS (INDIAN HEALTH)

Moderator: John Powless, Deputy Director, National Indian Health Board

Facilitators: Raymond Cross, Attorney, Native American Rights Fund, Boulder, Colorado
Bruce Davies, Attorney, Native American Rights Fund, Boulder, Colorado
Ellen Leitzer, National Indian Youth Council

In an opening presentation, NARF attorney Raymond Cross briefed the audience on the historical development of the federal government's position on Indian health care. He described it as having a lengthy past lost within the shelves of the nation's archives.

It was shortly after settling of the American colonies that the treaty rights of Indians were being developed. The immediate concern of the young country's political regime was to contain the diseases present among Native Americans from the country's non-Indian population. An "out of sight, out of mind" attitude prevailed. This policy worked to the detriment of the Indian and aided in erosion of the land masses which were being rapidly transmitted to the control of a budding nation.

The federal-Indian trust relations which developed are the important basis on which Indian rights were established. In present time, all too often, protection of these rights is left to the courts of law, while local administrative interpretations frequently serve to compound problems.

The whole issue of legal developments, stated the presenters, is at most a misnomer which evades the basic issue of "how do Indians protect and maintain their special rights as guaranteed by the federal government?" Indians have been forced into approaching the issues of legal development by assuming a submissive role. They are being placed in the position of defending these rights in the same courts of law which should be protecting them.

Indians today are faced with the issue of whether the trust responsibility and scope of the treaties, executive orders, and federal statutes can still be utilized in a period far removed from the distant past, workshop participants were told. The same congressional leaders who have the charge within the U.S. Constitution are confronting the Indian nations with proposed laws aimed at reducing and restricting the delivery of services such as health care. There are those within the bureaucratic structure who hold to the belief that treaty obligations are related only to the rights which protect Indian land.

The American Indian Policy Review Commission in its two year study begun in 1975 defined the federal-Indian relationship as "an established legal obligation which requires the United States to protect and enhance Indian trust resources and tribal self government, and to provide economic and social programs necessary to raise the standard of living and social well being of the Indian people to a level comparable to the non-Indian society." It is important to note that the findings of the commission are not rapidly finding their way into the volumes of the Code of Federal Regulations.

"Why haven't we seen a statement of national policy clarifying the scope of the trust responsibility?" asked Bruce Davies, another NARF attorney. In 1977, the policy review commission provided a definition:

> "The scope of the trust responsibility extends beyond real or personal property which is held in trust. The U.S. has the obligation to provide services, and to take other appropriate action

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necessary to protect tribal self-government. The doctrine may also include a duty to provide a level of services to Indians generally equal to those services provided by States to their citizens. These conclusions flow from the basic notion that the trust responsibility is a general obligation which is not limited to specific provisions in treaties, executive orders, or statutes; once the trust relationship has been assumed, administrative action is governed by the same high duty which is imposed on a private trustee."

Thus, there really is a special obligation of the federal government, but attempting to prove it often requires great effort by tribal groups. Davies stated that Indian people must actively exercise the rights bestowed when they "became citizens of their own homeland."

Ellen Leitzer gave a presentation prepared by the National Indian Youth Council in opposition to the contract health care provisions governing Indian health services. She claimed that the regulations set up geographical criteria which unfairly excluded a considerable percentage of Indian people from health services.

For nowhere within the legislative history of the Snyder Act (the 1924 law which established the statutory foundation for the provision of services to Indians) is it indicated that Indian people would not have the freedom to select where they would reside, said Leitzer. Rather, she claimed, it has been through subsequent actions of the draftsmen of the federal regulations that parents have successfully been "pitted against sons and daughters."

TRUST RESPONSIBILITY AND the relationship between the federal government and Indian tribes were two of the major items of discussion at the workshop on Legal Developments. Ellen Leitzer (left) of the National Indian Youth Council, Raymond Cross (middle), Native American Rights Fund, and Bruce Davies (right), Native American Rights Fund, served as facilitators for the workshop.

Giving additional historical background of the present contract care situation, Leitzer stated that prior to April 1973, there was no distinction between eligibility for medical services provided by direct care and medical services provided by means of the contract care program. It was at that time that the IHS made the administrative decision "necessary to conserve funds for contract health services to those who live in the areas served by the IHS Health Services delivery systems."

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HUNDREDS OF CONFERENCE attendees (below) were graciously treated to a salmon bake and dinner by the Affiliated Tribes of the Northwest following conference activities the evening of July 23. Afterwards, the Northwest Portland Indian Health Board sponsored a pow-wow for conference participants; at right, NIHB Program Analyst Bad Hand sings while two younger participants (above) join in traditional dance.

Tuesday, July 24, 1979

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Second General Assembly

ETHEL GONZALES: The Second General Assembly of the Third National Indian/Alaska Native Health Conference will now come to order. I'll ask Agnes Nichols, member of the Alaska Native Health Board to give the invocation.

AGNES NICHOLS: It is a privilege to be here today. Our Alaska Native Health Board feels the invocation is a very important part of our life and the way we begin our sessions.

(Whereupon, the invocation was given.)

ETHEL GONZALES: Again, this morning on behalf of the National Indian Health Board, I would like to extend a sincere welcome to each of you for your participation in our conference this day. I would also like to extend a greeting to each one of you on behalf of the members of our Alaskan group. We are very happy to be here.

At our last conference in Albuquerque questions were asked about the problems we were facing in our state and one of the problems is in regard to health services. And one of the things we have to face is the isolation and long distances that we have to travel. I would like to give people some idea by saying Alaska is approximately ten times the size of the state of Georgia; about three times the size of the state of Texas. I would like you to recognize our group from Alaska so you have a chance to meet and talk with them during your stay here. We have a group of three tribes. This is a difficult time of the year for us to get away. Most of our people are earning a living during the summer months. They have a regular fishing season. Many of our people could not get away, but we do have a good group.

Speaking on behalf of our Alaska group, we are looking forward to meeting and talking and sharing with you throughout this conference.

The National Indian Health Board Planning Committee, in one of their initial meetings, had difficulty in selecting a theme for this health conference. We discussed several ideas before deciding upon the theme of this conference, which is, Our Vision: A Journey to Better Health. I know that each of you here today have families on reservations or in the cities who do not have access to the basic health services that are optimal to a healthy existence. It is because of this that I would suspect that each of you are here today; in an effort to learn some things and do what we can to improve the situation. Here is a thought to help you keep that goal in mind and in focus. By utilizing this theme to actually visualize the beginning of an improved health status for your people and to actually project that picture in your mind. A vision I see is more than a dream, it is an organized and planned image. It is an organized and planned image; it recurs because it is recognized as a needed element to make our lives what we want. It is a beginning of health, it is a spark. It is a creative energy from which everything evolves; it is the idea; it is the origin.

A vision possesses its own vibration from nature. Once this work is made, the spark is ignited. Traditional Indians would get together on occasion to create visions; and in this way, develop with clarity their perceptions of themselves as a people in total harmony with nature and the world around them. We can follow that tradition today.

I feel if Indian people planted this image, a vision of improved health services, improved health status, firmly in their minds and were faithful to it, there would be no barrier that couldn't be overcome to obtain that idea. As Agnes Nichols pointed out to you, the Alaska Native Health Board uses this idea or vision to retain strength and solidarity as a board.

Each board member carries with them a picture of a mountain in Alaska which is very special to us. That vision, that strength, and that unity has enabled us as a board to challenge some very difficult things.

I just wanted to share this thought with you, this ideal vision, this ideal thing; and the spark of energy that can come to light today by starting in our minds and seeing those things and devoting all our energy to that attainment. And by sharing this, I hope to plant the seed, this idea, this vision in your mind of what each of you can begin to do today, to bring about the new change of health care for your people.

Each one of the members of the National Indian Health Board and the staff is here to assist you. So I would encourage each one of you to feel free to ask any of us for assistance because that is why we are here. And again, I just want to say we are happy to be here and very happy to share this time with you. I'll ask Daniel Press to give us an overview of the legislative workshops that took place.

DANIEL PRESS: Before I get into the summary of the workshops, I would just like to express my own feelings that it is kind of hard thinking about the crazy things in Washington, about legislation, 638, 437 — I would like to thank the Northwest area health board who presented the beautiful event, last night's salmon bake; sitting on those hills, the night air clear, and the beautiful pow-wow. The amount of work that went into it. I heard there was 1,500 pounds of salmon. I just think they did a beautiful job. I'd like to thank all of the people who worked so hard to make this come about — but we have to get back to the craziness in Washington and the legislation. The various workshops apparently from what I've

41

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heard, went their own separate ways depending upon the character of the facilitator or moderator and the kinds of responses from the audience.

First getting to the workshops, I would like to call on Bob Price, who is Board Chairman for the Indian Food and Nutrition Resource Center, to discuss the activities of their panel and some of the technical assistance that will be available at the center.

What we are trying to do here this morning in a relatively short period of time is to give you the highlights — all of you had an opportunity to attend two workshops; there were nine, that means you missed seven — and try to give you a few nuggets of knowledge that came out by the facilitators and moderators.

BOB PRICE: Ladies and Gentlemen, it is a pleasure to be here and present some information that will be helpful to your people. As plenty of you are aware, in 1977 the Congress of the United States passed the Food Stamp Act of 1977. As an integral part of this act, there were specific Indian provisions — and I won't go into all of those.

Basically, I would like to go through the important ones: One, an Indian tribe or Alaska Native tribes, band, consortium, whatever specific designation that you prefer, that desires a commodity distribution program on their reservation could, in fact, have it whether they had it in the past or not.

The second main provision provided for automatic tribal administration of that commodity program; if that tribe could be deemed capable of such administration.

Thirdly, it provided for improvement to the commodity package which basically means higher quality foods.

The fourth provision was that the law requires states operating a food stamp program on Indian reservations or on Indian lands to consult in good faith with the tribal organization for that program and to maintain consultation with the tribes to insure that these programs are made responsive to the American Indian and Alaska Native people.

The fifth one provided for eventual tribal administration of the food stamp program should the state fail grossly in its responsibility to administer that program on behalf of the Indian and Alaska Native people.

And one other provision I'd like to mention is to provide up to 100 per cent administrative funding for the operation of either program's funding on Indian reservations, regardless of who administers it.

Now it's been two years since the act was passed and the Department of Agriculture has finally decided to publish rules and regulations for these provisions. They pretty much stuck with what Congress said. And this will create problems which I won't go into now. But, one of the areas is in the way they intend to define the term "reservation." There might be some problems for those of you who are from Oklahoma, Alaska, or some other areas where reservations aren't clearly defined in the general sense of the term. We'll later go into what kind of technical information or expertise might be available, if you are interested in those conditions.

I'd like to speak about the regulations. It is critical — and I want you to note — that these regs are sleepers — they are built so that they don't exist at all, unless the tribe comes in and initiates some type of action to the Department of Agriculture. They just sit there and sleep unless the tribe makes the initial move. It is important that your tribe or group make a request or complaint to the Department of Agriculture to initiate any action under the regulations. The Department of Agriculture will not come out to the reservation. They won't do anything at all. Your tribe must submit an application and there is specific information required. For those of you who want more information, we have some handouts. They basically want — I'll run over it quickly — where your tribal geographical area operates; your jurisdiction; they want to know your tribal population; they want an estimate of how many people will be participating in the program monthly; and some other statistical things.

Once you have an application in the department, the department has five days to acknowledge that application in writing. They then have 60 days to make a determination of whether your tribe is capable of administration of the program or not. They will base this solely on the information contained in the application. Therefore, the application has to be well done. Otherwise, they have another type of delay where they have 30 days to write back to you and say, "We need further information." At this point, once the capability of the tribe is determined even if it requires training and technical assistance to become capable the Department of Agriculture is required to provide the training and technical assistance. It is at this point where they discuss this T and TA with your tribe. Once this is accomplished, there is a maximum of 120 days for the implementation of the program operation on your reservation.

The food stamp program is a little different. The only way the tribe can gain administration of a food stamp program is if the state operating that program on your reservation grossly failed to effectively and efficiently administer that program to your reservation members. In order to be clear on that and in order to determine whether there was gross negligence or not, use the complaint procedure. Again, let me emphasize — until a tribe steps in and says to the regional office of the Department of Agriculture, "We've got a problem with the state operating this program on the reservation, they are failing to offer aid to our

people" and it is well documented, USDA will do nothing. Then, they will consider nothing but the piece of paper from your tribe to determine whether your request or complaint has merit.

If it is determined, in fact, that your complaint has merit, an administrative review will follow. Once they begin the review, they have 90 days to determine whether to activate state payment or not. There is no time limit that they have to respond to this direct action plan, which has some language about whatever the scope of the efficiency is; whatever the scope of the plan is; and the amount of time used to implement that plan.

Now, once they have gotten through the procedures and the state still fails or refuses to respond, the department has to determine failure on the part of the state — and it is at this point that they begin to look at the tribe in order to turn over the administration. Then they start looking ahead to see whether the tribe is capable. They want to know how experienced you are in operating federal programs; what the scope of those programs is; what your personnel system is like, and what your past contracts, grants, and records are like. That's what they base their decision on. After they have determined that the state has grossly failed, then they will begin providing technical assistance and training to your tribe.

Your tribe needs to make a few initial decisions: What kind of program do you want on the reservation? Do you want a commodity food program on your reservation all by itself? Do you want a food stamp program alone, or do you want both operations? If you decide you want both programs on your reservation send your application to the Department of Agriculture specifically stating that you want concurrent operation. It takes about five months to initiate a request for the commodity food program. And then it takes about four more months from the issue of the request or complaint to the Department of Agriculture before you find out if you are allowed the food stamp program. Then it takes an additional three or four months to begin the implementation depending upon what administration you have. So it is very important that a tribe immediately think about what it wants, make its decision, and initiate a request to the Department of Agriculture.

During the past few years, our people haven't really benefited from it yet and when the legislation comes up for renewal, I believe that if we don't get something done now, our tribes won't participate in the program at all from the day is was initiated. There are some very strong congressmen who do not like Indians in general, who fought these provisions and continue to fight them with strong will.

I think it is important that we begin to participate in this program, then it makes it a little bit harder for a little congressman, who may be powerful, to take this program away from the Indian people. Whereas it is now, the small participation can put an end to this program.

DANIEL PRESS: The Indian Food and Nutrition Resource Center is a subsidiary of the National Indian Health Board and as a result we have had a chance over the past few years to follow the activities of Bob and the other people who are working for the tribes and who formed the organization. They have been put through the bureaucratic ringer, both by the Department of Agriculture to get legislation through, and by several federal agencies to get funding for the technical assistance research center. I have been tremendously impressed by the diligence — I think these people have spent more time in Washington than I do, and I live there. They are back there every couple of weeks fighting bureaucrats, helping policy, pushing, pushing, pushing. I think through the years the record will show it paid off. They got regulations and we are going to have our resource center. So I recommend that you take advantage of the legislation. Also, take advantage of these particular people at the food and resource center. For the time being, until they have a phone number, contact Bob Price, Director of the Commodity Food Program, Papago Tribe, main switchboard. Or you can call the National Indian Health Board and the board will serve as a link to the resource center until it has been established.

Our next panel speaker will be Bill Wilson.

BILL WILSON: I appreciate all the people that turned out, both of them. No, we had a very good time at the workshop. It was moderated by Dr. Marlene Haffner and we had a panel of experts.

As I was telling Dan before, we built what we call a health care backup. That is, taking a student from kindergarten up to the twelfth grade interfacing him into a college area and then interfacing him to a professional school. So without actually going into all the steps we talked about, that's basically what we did there.

There were a number of observations made. One of the most important resources Indian people have are their young adults, the kids coming up, and the development for their young people. It is imperative to all Indian people.

Another thing that was discussed — questions brought up — how do you identify a child down in the grades? As discussed in the workshop, you can't do it. But you know one thing, if that child doesn't pick up his grades, you know there is no way he will ever complete that slot in a professional school. Again, you have to have some basic skills, that is, language skills. He's got to have math, he's got to have science. If you tried to take away the science and try building him another field, he still has to have language skills. I don't

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WILLIAM WILSON, Executive Director of the Association of American Indian Physicians, summarizes highlights of Indian Health Manpower Workshop during Second General Assembly.

care what profession, he needs language skills. If he makes a decision to go into the health profession, he can always pick up the science courses in college. And there are programs that will fund that type of activity — 94-437.

We as Indian people, I think, are self-determined. We need to train our own people. We need to build our own resources. We concluded the workshop with a resolution requesting the National Indian Health Board to support Indian Health Manpower Development. And here again, is something that was discussed earlier. People talk about, "What is Indian Health Manpower Development?" Very simply it is in school. Perhaps they could go into the health professions or helping the health professionals.

DANIEL PRESS: By the way, there will be a two- or three-page sheet summarizing the highlights of the workshop. The material will be available to you sometime today and there should be some information on every one of the panels to take home to your tribes.

I would like to ask John Powless, Deputy Director of the National Indian Health Board, an attorney, to come up and talk about the legal developments workshop.

JOHN POWLESS: During the workshop, we discussed a number of issues with the recent developments in the Indian health field. We touched on contract health care regulations; we touched on White versus Califano dealing with the trust responsibilities of the Indian Health Service. We touched on cases dealing with the Resource Allocation Criteria and the funding of the tribes in California and indications that that case has said an increasing amount of funds need to be made available to the California tribes. We also talked about whether or not the right to health care was a right we as Indians are entitled to or whether we just receive it by the grace of the federal government. We talked a little bit about Public Law 94-437, and its implications of trust responsibility in planning for Indian Health Service.

I'd like to go into a case that I strongly recommend you consider, if not yourself, maybe have your tribal attorney request copies of an analysis that is being done in connection with the Indian health board with respect to the Califano case. It has some very broad implications about trust responsibility to the Indian Health Service. Let me touch on that case very briefly so you can get a flavor for its implications.

In White versus Califano there was a lady by the name of Laura Smith, who was being committed involuntarily to a mental health institution by her family. As a result of the efforts of the family, she was later admitted to a facility in California. The State of California refused to provide her services claiming it did not have trust responsibility to these Indian people. They said it was the government's responsibility to meet their health care needs. And they also stated they did not have jurisdiction over this person because she came from the reservation and the case was started from the reservation. Therefore, it was a reservation matter and directly a health service matter. The responsibility for meeting the needs of this individual was on the part of the tribe and the Indian Health Service.

In deciding whether or not the Indian Health Service had a trust responsibility to this individual Indian person, one thing the court looked at was the implications, the legislative issues behind Public Law 94-437. The court came to the conclusion that the Indian Health Service did have a trust responsibility to meet the needs of this person and that their funding priorities had to be adjusted in order to meet her needs.

The court also recognized the fact that a lot of times when Congress passes legislation like 437 they never put the money behind it and accomplish the objectives. So the court did recognize that the Indian Health Service was under some severe monetary restraints in trying to address the mental health needs of the Indian people. But they did not let that deter them in coming to the conclusion that there was a trust responsibility that the Indian Health Service had. The court said that there was a specific section of 437 that went to mental health and that funds from that section should be appropriated to health care needs of these people.

There were also questions raised as to whether the Indian Health Service was a primary or residual health care provider. As a residual health care provider the Indian Health Care Service was arguing that the state had primary responsibility because these people were also state citizens in addition to being tribal members. Therefore, they were eligible for services of the state. So the Indian Health Service considered itself a residual provider, that means, they relied on others before they could actually get involved. They said they were not the primary health care providers and the

courts in essence, said, "You can call yourself anything you like — residual or primary — it doesn't make any difference to us. The fact remains there is a problem with Public Law 94-437, which indicates you have a trust responsibility to the Indian people and, therefore, under that law you should be addressing the health care needs of these people."

The court went on to rule that the state did not have the responsibility even though Smith was a citizen of the state of South Dakota. So that is the present law in the federal district up in South Dakota. That federal law can have broad implications in other areas such as the contract health care regulations.

Now, in discussing the contract health regulations, we discussed different classifications that have been developed by Indian Health Service in providing contract health care to the Indian people. The primary rule brought up dealt with county classifications. Whereby, if you are an Indian person and you live in a county that is adjacent or connected to the reservation, you are eligible for contract health care. But if you live in a county that does not connect to the reservation, then you are not eligible. We got into discussions about the implications of the Snyder Act and the implications of Public Law 94-437, and about the distinction between on reservation and off reservation.

We talked a little bit about the definitions dealing with close economic/social ties to the reservation. One of the recommendations that came up was that tribes should be encouraged to appeal the rules and regulations, or, at least, a designation of boundaries of where their people have their services. These classifications or determinations can be appealed to the Secretary of HEW. If you're in disagreement with how the county situation is set up or how the contract health care regulations are going to be applied to your people, you can appeal those determinations that have been made by the Indian Health Service people to the Secretary. You can try to get the boundaries changed. This does not mean they will be changed, but there are appeal mechanisms within the law.

Another thing we talked about was where the contract health regulations did not apply, such as in the states of Nevada, Oklahoma, and California. These are the states where the regulations did not apply because of jurisdictional problems and the physical location of the tribes; and the relationship between the tribes and states, such as in Oklahoma.

The recommendations from our workshop will strongly emphasize that the Indian Health Service does have a trust responsibility to the Indian people in meeting our health care needs. This obligation cannot be transferred to the states. The state is not the trustee of Indian people, the federal government is. The basis of that comes from laws such as Public Law 94-437, wherein the federal government has recognized the unique legal relationship that exists between the tribes and the federal government.

There also needs to be a heavy emphasis on the tribes and their treaty rights. The tribes should be recognized as nations, not as political subdivisions of a state, not as political subdivisions of the federal government, but as nations based on the treaties that we have signed with the federal government, which are still valid. These treaty rights need to be maintained and enforced within the whole federal system; particularly, with the Indian Health Service.

DANIEL PRESS: I think the issues that John talked about are very important and are going to be key issues in the coming years. Over the past 10 years or so IHS has developed the concepts of residual versus primary. I think the vast majority of Indian people and their attorneys see IHS as the primary provider. However, in order to be able to obtain money from other sources or third party beneficiaries such as Medicare, Medicaid, Vocational Rehabilitation, and state and local programs, IHS developed the concept that it is the residual provider and these other third party resources have the primary responsibility to serve Indians. However, in doing so, and I think unintentionally, in their pragmatic search for additional funding, I think they have begun to deteriorate the special rights that Indians have and the concept of Indian Health Service as a trust in response to the trust responsibilities of Indians.

I think the challenge in the legal context in the next couple of years in the area of Indian health will be in the areas that John was talking about, which is to find a way to get these additional kinds of funds, these third-party resources without threatening or, in fact, deteriorating the special rights. I think they need to accept the fact that they are the primary provider in terms of the special relationship, but still be a residual provider for the purposes of third-party resources.

I hope they will begin perceiving the damage they are causing and will find ways to be a little more subtle in their approach. I think the lawsuits that John talked about are the first steps in persuading them to be a little more subtle.

The next workshop is the Area Health Board Workshop and I would like to call on Ron Hodge, who serves as attorney for the Alaska Native Health Board, and has been a real strong force helping the board develop its Memorandum of Agreement. The Alaska Native Health Board was fortunate enough to have Ron, who was able to tell IHS and HEW how they could do things. In fact, one of the issues that we keep hearing is that you can't use 638 or other funds, grants to health boards, or tribal health departments to hire attorneys; this is nonsense. There is nothing in the

federal regulations that prohibits you from using contract funds or funds given to you to run your health boards to hire an attorney, and I think they are necessary. If IHS shows up with their attorney and if you don't have yours, you are severely handicapped. So don't let anybody tell you you can't because you can.

I would like to call on Ron Hodge.

RONALD HODGE: One of the things we started to do when we first opened up the workshop yesterday was to talk about the Memorandum of Agreement and what it is. In the state of Alaska, we utilized a Memorandum of Agreement to enter into a partnership agreement with the Alaska Native Health Service, in the area of program planning and in the area of assisting and administering programs. A great number of lawyers throughout the country who are working for the United States felt that this idea was not possible. What we are attempting to do in the state of Alaska is to have more than just an advisory capacity. We wanted to assist in the planning elements and provide a resource to the area director; to make sure that the needs of the Alaska Native people are directly met. The unique aspect of this is we have an automatic choice to the director of the Indian Health Service, if the area director denied our recommendations. So from that basis of the Memorandum of Agreement, our workshop started to look at other possible problem areas.

We looked at the area health boards' understanding the federal system regarding contract and procurement. I feel that this is the next area that the Alaskan people want me to look at. They told me and the board that the procurement system in the state of Alaska and representing the United States needs definite legal attention. By that I mean that the provisions in the contracts we presently enter into diminish your rights substantially. For instance, the key personnel provision states that any time you change assignments or otherwise transfer key personnel within your corporation, you have to get permission of the contracting officer. We feel that that provision has been misused because the United States really runs our health programs, if that's the case.

Further, the advance payment provision within the contract provides: The contracting officer at any given reasonable time — to himself — can monitor our programs. Once again, the United States is running our health programs. Further, anytime we have a subcontract, out-of-state travel, or insurance claims, or anything like this, the contracting officer has to be immediately notified and has to provide approval. We in Alaska maintain that that means the United States is running our programs and that cannot continue.

Furthermore, the workshop developed the concept that during negotiations for contracts, negotiations must be filed by two parties, whereby you can determine what provisions you want in your contract and what should not be there. The workshop resolution states it is necessary for us to start looking at negotiation sessions between the contracting officer in our Alaska area and regional health board corporations and other area health boards.

In addition to this, we went into the concept of a cost benefit analysis that should be an undertaking of all area offices and the National Indian Health Board itself to determine whether that money being allocated by Congress is efficiently and effectively provided for native and Indian health care. This cost benefit analysis is essential because under the terms of the Indian Self-Determination Act, it is necessary at the beginning of your contract to compute indirect cost rates and the cost of doing business under the particular program, which means you will have to know the costs the area offices have for maintaining themselves.

Further, we developed the concept that the National Indian Health Board must assert stronger leadership and direction in providing area and local boards the necessary elements of a comprehensive training program. The envisioned training would be a four- to five-day program for all boards. And this training program would provide a thorough understanding of the federal system and a thorough understanding of the legal ramifications dealing with the Indian Health Service

Next we looked at communication. One of the things done by the Alaska Native Health Board was holding a retreat for five days in which we discussed the attributes of being Indian and what that means to communication. In communication we said that Indian people have the ability to speak underneath or the ability to talk to themselves and other people in a different manner. The Alaska Native Health Board explained that and dealt with the issue in great depth. Because of that our board now goes in one direction and has established certain goals and priorities through this communication pattern.

The other element we looked at was health care alternatives. Indian people are like any other people throughout the world, with a right to choice. And that choice means we have the right to look at other health care systems besides the Indian Health Service. One of the other systems mentioned yesterday was the possibility of developing a Health Maintenance Organization. In the state of Alaska we are looking into the feasibility of establishing a private insurance company owned by native people with the capital formation being undertaken by the regional profit corporations and other private companies; whereby, we can have our own insurance and choose our own alternatives. In addition to that we stated that the Indian health plans, in our view,

were not geared towards alternative health care systems. We have to look at the health plan dealing with alternatives rather than just one system.

The fifth area we dealt with rather extensively was the development of capital, the additional monies, that perhaps we needed to start health care systems. Where would they come from? And once again, in the state of Alaska, we deal with regional profit corporations that have sufficient capital and we are looking into the tax advantages now of them making contributions to alternative health systems to the state. Down in the 48 states Indians possess a tremendous percentage of all natural resources. Perhaps tribes could get together and develop these.

In summary, the status of area Indian health boards should reflect individuality and pride, direction and goals assisted by the National Indian Health Board.

DANIEL PRESS: I think each area is different, each tribe is different, you will want to modify that to your own particular circumstances. I think it is a basis for viewing a new, equal partnership relationship between boards and Indian Health Service. It is a brilliant model and should be viewed by all. If you need a copy, contact the Alaska Native Health Board directly or contact the National Indian Health Board in Denver and they will see that you get a copy of it.

In the interest of time, I'm going to apologize to the facilitators of the workshops and will skim through those remaining.

The workshop on the 1980 Census. It described the general census process and also the supplementary questionnaire on Indians, which includes a number of questions about Indian health. The information that comes in response to those questions will be very important in persuading Congress about Indian health needs and providing both tribes and Indian Health Service with the precise data that they need to form decisions about the health needs and health programs of their people.

There was some concern expressed in the group that this supplementary questionnaire is not going to be used in California or Oklahoma. My guess is that it may not be too late to try to persuade the Census Bureau of these two states to use the supplementary form because the specific data on Indians in those two areas are as important as anywhere else in the country. It shouldn't be ignored.

Lastly, there were recommendations about forming advisory boards in preparation for the 1980 Census. One recommendation was that there be one on the national level. The Census Bureau representatives weren't sure they could do it. However, it may be advisable to the national Indian organizations to establish a board to try to provide continual oversight and direction to the census.

More importantly, however, is the work that goes on at the tribal level. Each reservation is different. The problems the census enumerators are going to have identifying people, locating all the homes will vary from reservation to reservation. So each reservation is going to have to — if they want to insure that every member of their reservation is counted — recommend an established advisory board for the 1980 Census to work with the census enumerators, to help them uncover the unique problems on that reservation and help to find ways to overcome those problems so everyone is counted.

I mentioned before, the people working in the health field are very appropriate people to take the lead in this, both because of the direct contact with all the people on your reservation and because of the importance of the census for the health programs.

As we all found out in our discussions over 437 — in fact, switching into the 437 workshop — one of the recommendations was that the 437 plan process utilize the proper population census, rather than the U.S. Census. However, I think the U.S. Census will be the official data. So all we can do is make sure that the problems that happened in 1970 do not recur in 1980.

The focus of the 437 workshop was in direction to both the IHS and the National Indian Health Board. There was a request that the NIHB should push very hard to see that Congress and the Administration follow through on the commitments regarding the tribal and urban health plans once they are submitted. I think the national board would be glad to carry on that responsibility, realizing its importance.

There were recommendations that traditional medicine be included in the Tribal Specific Health Plans. For most of you it is too late to make any major changes in your health plans, but it is the expressed objective of the Indian Health Service to make this process an annual one. Each year you will update the plan, based on changes that occurred during the year; new facilities, new problems, new policy directions, goals, and so on. One of the recommendations of the group was when you do it in the coming years that IHS be advised to consider traditional medicine as an appropriate form of tribal health care. We will talk a little bit more about that later. Also, the emphasis that since IHS is expanding Tribal Specific Health Planning as an annual concept, that funds be made available to the tribes to do that planning.

Lastly, it was mentioned that tribes should take advantage of the opportunities that 437 presents to deal not just with financial and budgetary problems, but all of the rough edges, policy problems, policy changes, not just in Indian Health Service, but in all of the health and health-related services that the federal government makes available to Indian people. That ranges from the health programs, such as Medicare and Medicaid to housing, sanitation, food and nutrition, because all of those have as much of an

impact on the quality of health as the medical services IHS provides.

The next workshop was on Contracting, Grants, and inter-governmental Personnel Assignments. The contracting aspects of the workshop *focused on two new mechanisms available to* tribes. One is the Joint Funding Simplification Act, which allows tribes to put all of the different grants and contracts into a single document and that can be the money you get from BIA, from Indian Health Service, from CETA, from EDA, HUD, and so on down the line. These can all be combined into a single funding vehicle from the federal government to the tribe. Generally, the federal agency has the largest amount of money and will serve as the lead agency and the other agencies will transfer their money to that agency. If that is a complex and difficult step to take all at once, you can combine all of the programs you receive from Indian Health Service and HEW into a single grant contract.

The benefits are that it reduces the time spent on negotiating contracts; it reduces the reporting burden; it reduces the burdens placed on your accounting and bookkeeping system. So if you feel like you're swamped in paper and that you can't get to effective work on your programs because you are so busy filling out forms, you should consider the Joint Funding Simplification Act procedure.

The other piece of legislation that was discussed in this workshop was the Cooperative Agreements Act which, as I mentioned yesterday, is a new vehicle for transferring money or programs from the federal government to tribes and other units of local government. It recognizes that there's a difference between a relationship between the federal government and an Indian tribe and between the federal government and the manufacturer of paper clips. IHS facilitators told the group that the Public Health Service is still having problems issuing regulations on the Cooperative Agreement Act. So it is not a tool immediately available to you, but they are hoping within the next few months you will be able to take advantage of this and get out of some of the burdensome steps you now have to go through in negotiating federal contracts and grants.

I think there was also a feeling expressed in the workshop as well as in the area health board workshop that IHS intended not to treat the contract agreement process as a relationship between two equal bargaining partners, but has a tendency to dictate, a tendency to push around, a tendency to create law — like the one I mentioned before — that you can't use the money to hire a lawyer.

Contracting law is like any other kind of law, it is an art. There is no such thing as black and white on just about any question — it's very hard to say you can't do it, or you can do it. It depends on how you phrase it, it depends on how willing the contracting officer is to interpret the law in a certain manner; how flexible he or she wants to be and, ultimately, how strong of an advocate you are. There was a feeling that IHS has a tendency to deal with tribes as a black and white issue and not give them the flexibility that the contracting agreement regulations do provide. One of the things the tribes want to do is to set up systems that will alleviate some of the burdens they feel.

The next workshop was on Public Law 93-641 and National Health Insurance. A couple of years ago, I got up before the board and said that National Health Insurance is like a bus coming down the road, gaining speed and you either have to get on it or get off the road, but you have to do something. Well, somewhere between then and now the bus got four flat tires, the transmission fell out, and it ran out of gas. So it is still there sitting on the road and we keep talking about it.

Part of this insurance plan is under consideration by the Senate Finance Committee. The chairman of the committee, Senator Long, has introduced a plan; Kennedy has introduced a plan. The Carter plan has been responsive to the request of Indians that whatever National Health Insurance system is established, be one that recognizes the unique nature of Indian health services. However, there is no feeling that these plans are in imminent danger of being adopted.

On 641 there are more positive things to report. 641 has created problems among tribes because they feel it is usurping certain tribal powers. The National Indian Health Board's core group on 641 and National Health Insurance has been working on two fronts to deal with that problem. There's legislation that has now passed both the Senate and the House, as of last Thursday afternoon, which in one way or another establishes the principle of the tribes as the primary entity responsible for health planning for their reservations. And HSA's have no business meddling in their affairs, which is a paraphrase. The legislation needs to go to the conference committee so it will be another month before there is legislation, but we are optimistic that there will be a clear congressional mandate that tribes have not lost any of their sovereign powers from the adoption of 93-641.

In addition, the core group has been negotiating a policy paper with HEW that really repeats the same thing. It sets out several principles. Foremost, the one I just mentioned about tribes as the primary health planners for the reservations.

It encourages cooperative agreements between the tribes and Health Systems Agencies, which can be beneficial in improving the quality of health care the Indians receive when they leave the reservation for contract care or for other purposes.

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Again, a lot can be gained. However, if you have an HSA which is hostile and has all the racist attitudes of the community where it is located, you now have the right basically to tell them, "Leave me alone." You cannot totally exclude yourself from the Health Systems Plan; they refused to allow any blank holes to fall in the Health Systems Plan. We tried to totally exempt Indians from 641, but Congress refused to. Instead, the tribe can say basically our Health Systems Plan has already been developed and it is called the Tribal Specific Health Plan. That should be incorporated pretty much intact as the tribes' portion of the Health Systems Plan developed under 641.

Secondly, HSA review and comment authority has been a problem and HEW will be sending directions to the HSA's and to the regional offices that review the proposals submitted with comments indicating that HSA's only have the right to review and comment and they are not to use the language to indicate approval or disapproval.

In some cases, the HSA's have said that a proposal is duplicative with services available in the non-Indian community. Once this policy paper is adopted, which is still a month or so off, HSA will not be able to call an Indian program duplicative unless it can demonstrate that the program available in the non-Indian community is available and accessible to the unique needs of Indians.

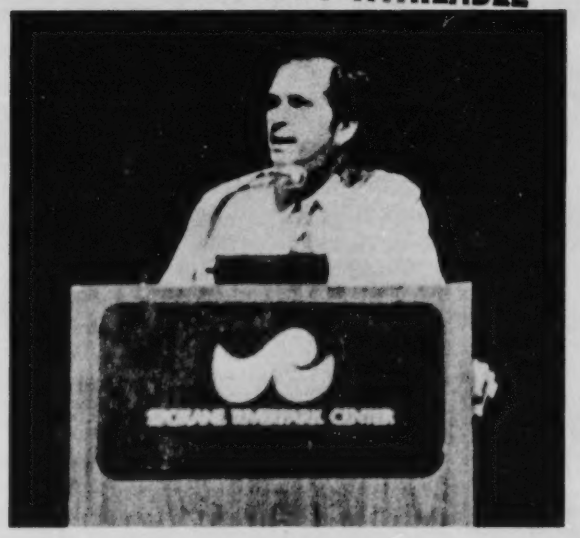
Lastly, there's a section dealing with urban Indian health programs which suffered from the same problems of being accused of being duplicative. HSA's will be directed to be sensitive to the reason why urban Indian health programs exist and to treat their programs accordingly.

The traditional medicine workshop, I think, was by far the most popular workshop and the one that excited people the most. I'm unqualified to talk about it. I will try in a few words to describe what Ed Tso told me after the session. However, I think, because of the excitement it generated, at the next health conference there will be a great deal of time devoted to it.

The principle that the traditional Indian medicine workshop was seeking to establish was that traditional Indian medicine must be treated on par, in the same manner as western medicine. The federal government puts all of its money into Western medicine and no money into traditional medicine. They are missing out on a very important and effective vehicle for improving the mental and physical health of Indian people.

Ed was saying that when man was created he was created with a balance between his mental and physical ingredients. That balance has remained the same ever since man was first created. When it gets out of balance, man becomes sick and the function of the medicine man has a great effect to bring a person back into harmony.

The workshop started with a discussion on reimbursement of medicine men for their services.



NIHB GENERAL COUNSEL Daniel Press conducts panel presentation for reports on previous day's Legislation Workshops.

It quickly expanded into a much broader view of the problems of Indian health and the solution to them. Alcoholism, suicide, drug problems — those are mental health problems. Those are problems because people's ingredients are out of balance. The Western medicine system has always been incapable of dealing with those problems effectively, while the traditional medicine system is designed specifically to treat those problems.

The key for the Indian people in the future, according to Ed Tso, is to revive the spirit that they had before they were ravaged in so many ways by Western society; the spirit that they had when they controlled this land for thousands of years. Only when that spirit is returned will they be healthy and the key to returning that spirit is the traditional medicine system, which is, health, religion, what we in modern terms call the holistic approach.

They propose that we now talk about three bi's: bilingual, bicultural, and bihealth. Bihealth means traditional medicine and achieving its equality in the health service area.

If Ed could have been here, he would have generated much more excitement than I have. I hope all of you will have an opportunity to see Jack Jackson and the representatives of the Navajo and other tribal medicine men programs at future conferences. To me, that is the most exciting and potentially successful thing; that makes all the little legislative numbers immaterial.

I guess the message I would like to leave with you today is that the legislation we have been talking about, the health boards, the Memorandum of Agreement, and traditional medicine, are tools. They are available for you to use. Now, the

challenge is for you to take the tools and information we have given you and go home and put them to work to help your people.

ETHEL GONZALES: Now, to give you an idea of the Human Services workshops that will be held this afternoon, Jim Smith.

JIM SMITH: Good morning, ladies and gentlement. It is a real pleasure for me to be here and have the opportunity to work with the national board at this conference. I think as we look through the programs that have taken place yesterday and today and the rest of the week, we are going to have one of the better conferences this year in terms of productivity and in terms of sharing information.

As I was looking around, we have people representing everywhere from Florida to Alaska, from Maine to California, with many, many different tribes representing many different professions, backgrounds, just a whole host of different individuals. Yet as we look around at each other, I think, we find we have one thing in common — I see that we all care. I think that's why we are here. We care about our own health; we care about the health of our fellow man; we care about the future health of our children, our loved ones.

We came to this conference with a lot of concerns; with a lot of things that we see as still needing to be done; and yet, if we stop and reflect a moment what's happened in the past few years, we have seen a lot of changes occur already. We have seen a lot of new programs started. We've seen disease rates go down. We have seen birth rates increase. We are seeing a reduction in death rates; we are seeing a lot of changes. We are even seeing a change now in our life expectancy as Indians. We have a life expectancy of something like 66 years, which has increased. It is still down from the U.S. population which is about 72 years. So, if we can take advantage of what is being said at these workshops, what is being shared, we can help change things even more.

The greatest change that I have seen in the past number of years since I have been involved with Indian health is sort of demonstrated by this conference this week — and that's involvement. We talk about involvement. We talk about self-determination. But I think as we look today at all the people from all over the country here being involved, showing concern by coming all the way here to Spokane, sharing information; sharing ideas; that's really where we're at.

Yesterday for the most part the workshops related to the legislative issues and many of the things that are facing us in the future. Today we are getting into the day-to-day operations, so to speak. I like to think that we are really going to get with what is going on right now. So I'd like to briefly go through a little bit of the programs that the workshops will include today. And see if we can't generate some interest and hopefully — we've got about nine different workshops — you will be able to make some decisions as to what you would like to attend.

Starting off with the top of the list — at least in my book — is probably one of the most important workshops we have anywhere because it is one of the most important problems and that is alcoholism. I would guess if we went around the room that every one of us here has been affected by alcoholism. Either by ourselves, one of our family, a friend, or an acquaintance, who has problems with alcohol.

Only a few years ago, alcoholism began to be recognized as a disease. Before that, it was kept hidden; it was something to be ashamed of and nobody wanted to admit it was a real problem that needed to be addressed head on. Fortunately, that has changed because now it is being recognized.

With the passage of the Indian Health Care Improvement Act, the Indian Health service now has legislative mandates to become involved in addressing the issues of alcoholism. Prior to that for the most part, we ended up taking a position of saying that it was the responsibility of another agency. Finally, we are now getting into the area where things can happen. We're seeing more and more treatment programs developed. We are seeing them operated by tribal governments and we are seeing them being successful. I think this really says a lot in terms of where we are going.

The workshop today will be divided into two sections. The first hour will be headed up by Bud Mason, who is Director of the Indian Health Service Office of Alcoholism. He will be addressing several issues. Specifically, number one, will be the management of alcoholism programs that have reached their six-year maturity date and have been transferred from the National Institute of Alcoholism and Alcohol Abuse to the Indian Health Service. Secondly, along that same line, there will be the integration of alcoholism and alcohol abuse programs into the IHS delivery system in order that they, in fact, may get the recognition and emphasis that is so badly needed. Thirdly, Bud will be touching on the expectations of the Department of Health, Education, and Welfare and Congress to reducing the level of prevalence of alcoholism among American Indians and Alaska Natives to a level equal to or below the national average. Right now, the level of alcoholism among the Indian people is five times higher than the U.S. population.

The second half of the discussion will be conducted by Dr. Andre, who is from the Indian Health Service Mental Health Center in Albuquerque. He will be presenting data in regards to alcohol-related studies, including slides. I think if any of you have not seen such a presentation, basically, what this is going to do is show you the effect of alcoholism on a person's system. I'll tell you, it sure makes you think about having another drink.

The second workshop, I think, goes along with alcohol abuse and that is an area called Substance Abuse. This is an area that is growing more and more in concern lately. We spend a lot of time talking about alcoholism and alcohol abuse, but we never seem to want to address the fact that on the reservations now we are seeing more and more substance abuse — things beyond alcoholism.

This workshop is going to share with you information on substance abuse and various types of resources that are available, training that is available, and how to get involved in developing substance abuse programs. I think you will find this one also very interesting. This program will be facilitated by Albert Pooley, who is President of the American Indian Resource Organization.

The third workshop this afternoon will be on Emergency Medical Services, which I have been involved with for quite some time and have worked with John Emelio, who will be the facilitator on this program. We have seen the abnormally high incidence of morbidity and mortality on Indian reservations caused by accidents, injuries, trauma, and heart disease. These have more than demonstrated the need to have adequate Emergency Medical Services.

We've heard for years tribal health leaders talking about the importance of having a decent system, having an ambulance service. Yet it always took very low priority when it came to funding. Less than 10 years ago Emergency Medical Service programs on Indian reservations were practically nonexistent. Fortunately, things are beginning to change.

The Emergency Medical Services Systems Act of 1973 calls for national control of such services. The Indian Health Service has accepted the responsibility and is attempting to provide those types of services. This action by the Indian Health Service, coupled with action by tribal governments, has now, I think, brought ambulance service practically to all reservations in the United States.

Part of the difficulty we face on these are that most of the programs are funded on a one-time-shot-type thing and they operate on a year-to-year basis. So each year is a constant struggle to find ways to get funding, how they are going to operate, and how they are going to keep their existence in the coming years.

These are some of the types of problems that will be discussed in this workshop. They will be discussing funding items; how do we get into the next step of developing what is now being called the First Responder System? How do we go about integrating various local agencies like the police, CHR's, fire departments, and so on in order to develop a unified force with a First Responder System?

In addition, Mr. Emelio will be sharing with the group the latest developments in terms of training activities that are available. As I said before, this program will be facilitated by John Emelio, who is the Director of the Indian Health Service Emergency Medical Services Program.

Number four is a workshop which is very dear to all of us and that's in regard to the Indian elderly. It's been proven that only a very small percentage of Indian people who are eligible for services under the Older Americans Act actually receive those services. In Fiscal Year 1979, approximately $4.5 million were made available to Indian tribes under all titles of the act. There are approximately 565 Area Agencies on Aging designated by the State Agencies, but only five of those are Indian Area Agencies. As a result, the Indian community has benefitted very little, if any, from this act.

In recognizing this situation, Congress included in the Comprehensive Older Americans Act Amendments of 1978 a special title, number VI, which provides for grants from the federal government to go directly to Indian tribes. The purpose of the action was to insure that the Indian elderly would be served by their own units of local government in response to their own locally-determined needs.

The establishment of this service mechanism was the result of at least seven years of continuous advocacy by the Indian community, which began back in 1971 at the White House Conference on Aging. Throughout that time, Indian people have maintained that the only way to get their own needs met is to be able to make that determination themselves and have the option of receiving direct federal funds.

Further, it was felt that the programs should be designed by the local tribal government, operated by the local tribal government, and controlled by the local tribal government in order to take into consideration the various cultural, traditional, and religious factors on each reservation.

In 1976 the need for a viable direct funding mechanism was strongly reaffirmed at the First National Indian Conference on Aging, which was attended by over 1,500 elderly from all parts of the nation.

Having the opportunity last year to participate in the conference — and I can say this with all sincerity — I have never in my life been to a conference that had more enthusiasm, more energy, more devotion to a cause than that group of people did. And I say to you who want to sit in on this workshop this afternoon, I think you will get something out of it. They are fantastic people and have done some tremendous, important work.

Workshop number five, Patient Rights. Have you ever wondered when you went into a hospital or a health facility just what your rights as a patient really were? Do you know what to do if you feel like somebody has mistreated you while you were there? If you don't, then this workshop you will want to sit in on.

In 1974, the Director of Indian Health Service issued a directive to all area directors stating that there would, in fact, be developed something called the Patient's Bill of Rights and that there would, in fact, be established a policy in which patients could file grievances or register complaints. I think that was about the first time that most Indian people had a feeling that they did, in fact, have rights as patients.

So most of the areas have developed something along this line but the Phoenix area went one step beyond this. They developed what they called patient advocates or patient representatives. These are persons who have been specially trained in the areas of what a patient's rights really are.

So this workshop will be dealing with what the Patients' Bill of Rights are and how they can be implemented, who has the responsibility. They will be talking to you about what a patient representative does; how the program was established, and how it can possibly be established at your reservation.

I would just like to say speaking from the systems standpoint that many people tend to think when they make a complaint that that's bad; I don't. I think you've got to have a system where people are able to express their concerns and have those concerns responded to. Instead of hampering with medical care, to me, the concept of a patient advocate should strengthen the relationship that exists between the patient and the health provider. This workshop will be facilitated by Elliott Booth, who is the Colorado River Tribes' Health Coordinator.

We have a modification, or maybe I should say a combination of the Indian Child Welfare Act Workshop and the Title XX of the Social Security Act Workshop. The Indian Child Welfare Act has the potential of being one of the greatest pieces of legislation we have seen in a long time. I would like to share a story with you. It reads:

"Billy, an Indian boy born on a Montana reservation, was placed in a white foster home when a marriage tore his parents apart. Later his foster parents moved to the East and filed for adoption. When his parents, Indian parents, their lives now mended, sought the return of their child, the eastern court refused and the tribal court order was ignored."

Another case — "When Susie, a five-year-old, was taken from her Indian parents after they moved to an off-reservation town, a white social worker had investigated and judged that Susie's home was inadequate. The house, which was a small rental unit, was shared by another non-related family. The social worker reported that the house had too few bedrooms and lacked adequate plumbing. Susie was later placed in a white foster family home." We've all heard stories like this.

Hopefully, the passage of the Indian Child Welfare Act will eliminate a lot of this. That act now provides standards that have to be met and provides procedures that have to be followed and really, in fact, gives back to the tribes more authority and more jurisdiction in terms of handling child welfare cases. I think those of you who have an interest in that would really enjoy that session.

As I said, we are going to combine the discussion with Title XX of the Social Security Act. Don Milligan, who is Chief of the Office of Indian Affairs of the Department of Social and Health Services in Olympia, Washington, will be facilitating that portion.

Title XX of the Social Security Act was enacted back in January of '75. It authorized the Federal State Social Service Program — and permitted each state to design its own program. But since that time, Indian tribes and organizations have been recommending and seeking an amendment to Title XX, which would provide direct funding to Indian tribes so that they can design their own systems.

This workshop will pretty much give you an update as to where we are four-and-a-half years later and what still needs to be done.

Another workshop, number eight, on Urban Indian Health Care, will be facilitated by Luana Reyes. Dan mentioned a minute ago some of the items in terms of National Health Insurance that tie in with urban health care as well. As I understand it, basically, they are going to get into a very broad range discussion of issues affecting urban health programs.

It's a little difficult for the urban health programs to have specific workshops because it seems like most of the things they are involved in are so interrelated. One of the concerns, for example, was over extension of the Indian Health Care Improvement Act where funding, in fact, is tied to that. If it isn't extended, then what happens?

They are very much concerned with the issues and terms of National Health Insurance recognizing that if and when — as Dan said if that bus ever gets down the road — that somehow it is going to have an effect, positive or negative, on the urban health care programs.

Speaking of 437, the Indian Health Care Improvement Act, we have a workshop which will be held in regard to recommending changes and/or additions to improve the act. For those of you who have read the act and are familiar with it, you know it provides for a lot of good things. At least, it sounds like it does. It also contains certain requirements. One of which states:

"Within three months after the end of Fiscal Year 1979, the Secretary is going to examine the progress made under this act and make recommendations to the Congress concerning any additional authorizations for Fiscal Years

1981-1984 for programs authorized under this Act."

During the past two years, I think, most of you have been involved in development of Tribal and Urban Specific Health Plans, which Indian Health Service will now be using as a basis on which to develop its response back to the Secretary of HEW for her consideration. That will be submitted in September.

The Indian Health Service has been attempting to come up with ideas and recommendations to make changes in and have sent out requests for changes through their normal 437 communication channels. They have gotten back quite a number of responses and, I think, Dr. Birch plans to share with you what those are. Also, to give you an opportunity, once again, to share with him other concerns and needs and changes which you may have.

The workshops will be conducted twice today, as they were yesterday. The first session starting as soon as people can get there. The next session starting at two o'clock this afternoon. Between four and five this afternoon, time will be spent for the development of briefing papers for tomorrow morning.

We will be asking the facilitators or the designees from the workshops to meet with you in the morning to present what's happened. And hopefully, you will find the workshops very productive, very stimulating and very informative.

ETHEL GONZALES: At this time there has been a request by Ray Kuehne, who is from the National Diabetes Advisory Board, to speak with you.

RAYMOND KUEHNE: I would like to bring something to your attention that I think is important to you at this conference, but was not put on the agenda and, perhaps, should be sometime in your future meetings.

I'm the Executive Director of the National Diabetes Advisory Board, which is a group set up by Congress about two years ago to review and to report to Congress annually on any and all aspects of health research, health care, education, or anything that relates to the problem of diabetes across our country. This is not only oriented towards the Indian people, but the board has taken an interest among the Indian people and I would like to suggest a few things you might want to do both at a national level and back in your own tribes and communities.

I am sure you are aware of the problem of diabetes. However, it's something which seems to be sneaking up on us. The problem is greater than the attention given to it. And that's probably because the effects of diabetes are not visible when you are told that you have the disease. The effects become known later when your foot is cut off because of gangrene, when you go blind, when your kidneys cease to function, or when you have a heart attack. Many, many of these problems are due to diabetes and, in fact, some cases exclusively to this disease.

The incidence of diabetes among Indian people is increasing and some people that have worked closely with the problem are calling it an epidemic. This needs to be addressed by the board at the national level and at the community level too.

Let me give you a couple of facts: In the state of Oklahoma alone, one Indian in your group every week has a foot amputated due to diabetes and this rate is increasing; at least 50 a year — going toward 70 or 80 possibly this year. In that state alone the incidence of diabetes is probably five to six times than that of the U.S. population. And similar problems exist in Arizona.

We have the best information on the problem in Oklahoma and Arizona. We do not have as much on the other tribes, but we are slowly starting to discover more problems. The problem, for example, is becoming evident to the clinical people on the Navajo reservation and among some of the Northwest Tribes and in the Minnesota area. In the Alaska area, for example, we always thought that there was no problem. Now, we are receiving information that there is a problem.

You may know that diabetes is of two major types — one type fortunately you have very little of and that affects mostly the young people and infants, all through the adolescent ages in which they are instantly insulin dependent. Rather, the type you have is called the maturity onset, which comes usually in the white population mostly around the age of 50 or 60. But in the Indian population it begins to appear very early around the age of 40 and younger. The problem is the complications that I have mentioned, which do not come up until about 10 or 15 years after the diabetes begins. And then it is too late.

The Indian Health Service has been doing what it can, but its resources are not adequte to handle the problem and they are not able to do what needs to be done to prevent the spread of this problem.

You may also know that there seems to be a very high correlation between obesity (or extreme overweight) and diabetes. In Oklahoma, where studies have been done very extensively, 97 per cent of the people with diabetes are or have been overweight.

Research has been done particularly at the Phoenix Indian Medical Center in cooperation with the National Institute of Health with the Indian Health Service as to what to do with this problem. A lot of research has been going on in Arizona and they have been able to help those people who are overweight to achieve dramatic weight loss. As a result, people who were on insulin went off insulin; those who had oral medication, were able to stop their medication and their diabetes was gone. However, within six months after they were released from the hospital and went back to the

community, their weight went back up, the diabetes returned, they were back where they started from.

The question is: How can the information that researchers now have learned be translated to help you and your people back home? In this area, the National Diabetes Advisory Board decided that there was a problem. So in our first report to Congress, about a year-and-a-half ago, we gave this one of our highest priorities. We told Congress that there were only three or four areas that we were interested in. One of them was to do something about this problem in the Indian population.

Our report does not get filtered through the Secretary of HEW; it goes directly to Congress. We recommended one way to approach this — not the only way — but one way. We felt the federal government should look at the problems of white society. Diabetes is a problem that comes when we have it better than we used to and the challenge is how to deal with that.

I will be available today if you have any questions. I also encourage you to write us. You can also contact the National Indian Health Board which has this information.

ETHEL GONZALES: I just want to remind you that copies of the papers developed in yesterday's workshops are now available in the lobby where the registration was held yesterday.

We will recess now to the workshops and will reconvene tomorrow morning at 8:30.

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Human Services Workshops

ALCOHOL ABUSE

Moderator: Virgil Gunn, Chairman, Health, Education and Welfare Committee, Colville Tribe

Co-Facilitators: Bud Mason, Director, Indian Health Service Office of Alcoholism
Ralph Dru, M.D., Physician Advisor, Indian Health Service Office of Alcoholism

Indian alcohol abuse has long been identified as the primary health problem confronting Indian people, facilitator Bud Mason told the audience of this workshop.

Mason recapped the history of Indian alcoholism programs briefly, noting that the unique aspect of the Indian alcoholism movement is that it developed from the Indian people themselves. In the early 1960's, recovered Indian alcoholics began organizing and directing requests for assistance to various federal agencies for help in combatting what they recognized to be a treatable problem.

The Office of Economic Opportunity provided funding for some of the earliest Indian programs. When Congress finally passed the law which gave birth to the National Institute of Alcoholism and Alcohol Abuse (NIAAA), this agency formally recognized the special problem that alcohol was for Indian communities. The law itself identified Indians as one of several populations with exceptional need. The NIAAA continued and increased the funding for Indian programs. Finally, with the passage of P.L. 94-437, the Indian Health Care Improvement Act, the Indian Health Service (IHS) assumed responsibility for the continuation and strengthening of Indian programs.

Current program funding from all sources amounts to approximately $20 million. Indian programs are being transferred from the jurisdiction of NIAAA to IHS after completing their six year funding cycle. These are the so called "mature" programs.

The IHS Office of Alcoholism, initiated in February 1978, is staffed with two individuals. One of the critical issues now being addressed is the need for additional staffing, especially to work in the areas of research and evaluation, and training and quality assurance.

The IHS Office of Alcoholism's immediate priorities are: (1) research into alcohol abuse and treatment modalities; (2) evaluation; (3) development of resource allocation criteria, e.g., manpower; and (4) data collection. There have been several nationally-structured committees working on these areas of concern, trying to develop coherent policies and guidelines. The IHS will continue to try to strengthen its involvement and support of Indian community programs, reservation and urban.

The magnitude of the Indian alcohol problem can be found in a variety of statistical data, all of which is truly disconcerting. Mason and Dr. Dru reviewed the enormity of impact which alcohol abuse has on Indian communities. Specifically, it was noted that alcohol abuse contributes to five of the ten leading causes of death among Indian people, including: (1) accidents, (2) cirrhosis, (3) suicide, (4) homicide, and (5) alcohol abuse itself as a primary diagnosis. It is estimated that 95 percent of Indian and Alaska Native people are directly impacted by alcohol abuse within their families or communities. Eighty percent of all suicides involve alcohol. Perhaps most startling is the statistic that nearly one-half of the total cirrhosis deaths among Indians occurs in women, yet programs for and concentration on Indian women's drinking are virtually non-existent.

A recent report to Congress identified eight major barriers to the receipt of services related to alcohol in the Indian community. Some of these included: (1) community disbelief that the patterns of Indian drinking can be changed; (2) alcoholism workers and health professionals are not adequately trained for rehabilitation and prevention activities; (3) inappropriate use of existing resources (such as halfway house beds used for detox, etc.); and (4) absence of negotiated objectives between alcohol programs and tribal/urban community leaders resulting in a lack of support for community alcoholism programs.

Some audience members raised the question of why accountability is suddenly required. Mason noted that Congress and the Office of Management and Budget are critically examining federally-funded programs for how money is being spent: to what end? What is being accomplished? He stated that it is necessary to show results in order to maintain funding. In this respect the IHS has a clear responsibility to provide technical assistance to programs in trouble in order to help them improve their performance and better

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ATTENDEES AT WORKSHOP on alcoholism listen to presentation about alcohol treatment projects. Workshop facilitators were Bud Mason, Director of the IHS Office of Alcoholism, and Dr. Ralph Dru, physician.

identify their objectives and goals. Accountability will have to be built in at the community level for programs to succeed.

It was noted that there is also a need to critically examine alternative treatment modalities and to recognize the importance of traditional medicine and customs in helping an individual recover from destructive drinking.

Dr. Dru provided a more detailed overview of the impact of alcohol abuse on the community by discussing in detail some to the direct impacts and clinical evidence of abuse on the individual as well as in the community.

Lastly, Mason noted that the likelihood for increased funding in the next few years is slim. The IHS recognizes that alcohol program funding has not kept pace with inflation, but there are not additional dollars to correct this immediately. He said tribes should examine internal resources and consider innovations in addressing the problems in the near future and should especially consider combining the resources of several agencies.

In the second of two workshop sessions, Yvette Joseph, Program Coordinator for the Colville Cultural Alcohol and Drug Awareness Program, reported on an alcoholism prevention program for youths which the tribe has sponsored. The target population is Indian young people, ages 8-18, and the primary focus is on developing positive self-image and self-concept on the personal and cultural level. This program addresses an important and neglected area of concentration for Indian programs nationwide. The only other prevention program singled out for mention was the Chemawa School program which combines education and treatment.

Workshop recommendations fell into six major categories:

1. Congress should appropriate necessary funds to staff and facilitate the mandate to address the problems of Indian alcohol abuse: The mandate inherent in P.L. 94-437 requires both programmatic and manpower support if this major health problem is to be effectively attacked and resolved, and the various indices reduced from their current high rates.
2. Indian communities should be given all possible assistance in developing their own human resources programs: Recognizing that there is enormous individuality between Indian communities, funding agencies should work with tribal people to help develop community-specific and culturally appropriate human resources programs, rather than planning from the top down.

3. Long range preventive programs should be developed and funded: It was maintained that prevention is a very crucial issue in the realm of alcohol abuse in that preventive activities get at the roots of the abuse, such as poor self-esteem and lack of meaningful alternative activities. Preventive activities include major education directed at women in the child-bearing years to help reduce the incidence of Fetal Alcohol Syndrome; and strong encouragement needs to be directed at the Bureau of Indian Affairs to mount coherent and comprehensive alcohol intervention and student support programs in the boarding schools, as well as educational assistance programs designed for implementation by community Johnson-O'Malley committees. Parents are appropriate targets for preventive activities as well as children and adolescents. And it was deemed important to involve the elderly in preventive programs as a significant cultural support.
4. Training needs to be provided the IHS professional staff as well as tribal and community paraprofessional staff: Training on a continuing basis is critical to long range efforts. The professionals in medicine and nursing need to be educated with respect to alcohol treatment and rehabilitation and paraprofessionals need on-going education in counseling, prevention education, and community organization. Training should be regional or local and on a regular and on-going basis. Tribes have a responsibility for providing orientation to medical professionals of tribal customs and traditions, and the IHS has a responsibility for the medical education of paraprofessionals.
5. Consideration and inclusion of the positive cultural attributes in dealing with community problems: A tribe's traditions and culture should be utilized in developing meaningful rehabilitation and treatment, as well as educational programs in combatting and preventing alcohol abuse.
6. Increased outreach services to the incarcerated Indian individual: The number of Indian people in prisons and jails as a direct result of alcohol abuse is over 90 percent, and the recidivism rate is well over 80 percent, yet there are few programs which address the very real needs of the incarcerated native. Support and funding are needed to develop intervention and rehabilitation programs for Indian and native people in prisons and jails.

SUBSTANCE ABUSE

Moderator: William Millar, USET Area Indian Health Service
Facilitator: Al Pooley, President, American Indian Resource Organization

As an introduction to the prevalence of drug use on Indian reservations, Al Pooley began with a report of a recent survey done on the Navajo Reservation which involved 505 students. He emphasized that this example was being cited in response to the general feeling among Indians that they don't have a drug abuse problem.

The survey involved five communities on the reservation. Of the students surveyed, 62 percent indicated drug abuse in the eighth grade and 85 percent in the eleventh grade. Only three percent indicated heroin abuse, but all were females. Alcohol, ranked first as the most abused drug. Marijuana was second and inhalants ranked third.

In the five communities surveyed, agency people were also questioned about substance abuse. The agencies involved included health, social services, educational, substance abuse and law enforcement. These people were supposedly experts, but they had very limited knowledge of the problem. They had only limited facts, and these are people providing services on a daily basis. The people in education were the ones who seemed to feel the problem the least. Principals and teachers said there is not much of a problem, while the students indicated there really was a big problem. There was an evident lack of communication in terms of resolving this issue.

Attitudes about the treatment of substance abuse among students differed widely, the survey showed. Some said to treat them as adults: convict them, put them in prison, and teach them a lesson. On the other extreme, we have those who said "make them all Christians and have them go to church" as a treatment. These are attitudes of people providing services, and demonstrates the need to be careful in choosing those who will be providing these services. The basic attitudes of people really have an effect and influence on the kind of services that are actually being provided in the treatment of drug abuse.

The National Institute on Drug Abuse (NIDA) has the primary responsibility for drug

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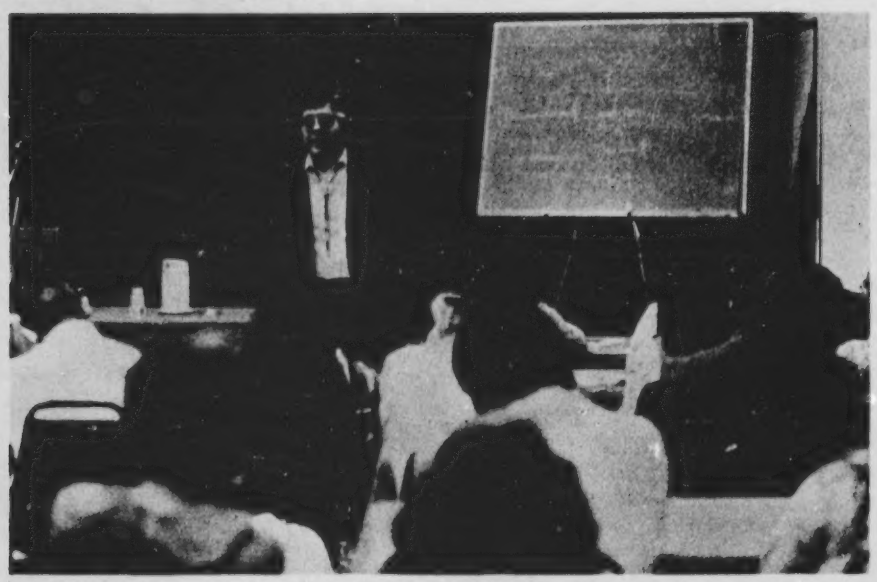

AL POOLEY, President of the American Indian Resource Organization and facilitator for the workshop on Substance Abuse, discusses results of a survey that examined problems of drug abuse on Indian reservations.

abuse, treatment, and prevention. Resources for developing drug abuse programs are divided into three main areas: (1) resource development, (2) community assistance, and (3) research.

There are two kinds of funding grants for developing substance abuse programs: "410", which are strictly for treatment, and "409", which are primarily for prevention. If tribes apply for 410 funds and are turned down, they should request a formal letter from NIDA explaining why the funds were denied.

Mr. Pooley responded to several questions from participants. Regarding the three percent of heroin use, he stressed that more research was needed to determine how this occurred, especially among females. Also, of the five communities in the survey, Ft. Defiance indicated the greatest incidence of all drug abuse problems.

The issue of peer pressure was brought up, and Mr. Pooley agreed this was a big problem to deal with since those students not abusing drugs appeared to be in the minority.

Introduction to drugs at home was questioned and Mr. Pooley responded that over 90 percent of the students surveyed indicated they wouldn't tell on their parents.

Mr. Pooley also stated that in the past Indian communities have been hurt by research. But now, we need *documentation* (through research) of the needs in Indian communities to get funding. We especially need "applied research" since it is helpful to know if the treatment being used really works.

EMERGENCY MEDICAL SERVICES

Moderator: Daniel Foote, NIHB Representative, Billings area

Facilitator: John Emelio, Director, Indian Health Service Emergency Medical Services Program

Workshop participants were presented with the background of the national EMS legislative authority as contained in P.L. 93-154, the Emergency Medical Services Act of 1978, and a description of IHS' current EMS program and plans for its further development in fiscal year 1980. The emphasis of next year's program will be on development of an EMS first responder program involving activities for Community Health Representatives, police, and others into an EMS systems approach; upgrading emergency departments in all IHS facilities; and a large-scale EMS training initiative.

Other expertise was lent the workshop by: Dr. Thomas Bonifield, IHS Research Consultant; Dr. Stanley Glenn, Albuquerque Area IHS; Julian R. Franklin, Chief of the Highway Safety Branch, Albuquerque Area Bureau of Indian Affairs; and David Means, Ambulance Director, Northern Cheyenne Tribe.

Bonifield spoke of current and planned EMS research and evaluation projects including a research project in Alaska's bush country and an evaluation project to measure the cost and medical benefits of the first responder program and the EMS Resource Allocation Criteria.

Dr. Glenn told of EMS operations in his area, including helicopter air-evacuation services provided by Kirtland Air Force Base.

Procedures for obtaining EMS highway safety grants under funds soon to be available from IHS were explained by Franklin.

Means described the excellent services offered by the Northern Cheyenne emergency response and transport program and also told of problems encountered in bringing the service to its present status.

Workshop participants adopted a resolution calling for NIHB and IHS to move swiftly to obtain line-item recurring funding for the IHS emergency medical service program with special emphasis on training of tribal EMS systems personnel and establishment of a full-time EMS field coordinator.

INDIAN ELDERLY

Moderator: C. S. Stitt, Director, IHS Portland Area

Facilitator: George Effman, Chairman, National Indian Council on Aging

George Effman opened the sessions with a brief background of the law pertaining to older Americans. In October 1978 at White House ceremonies, President Carter signed into law the "Comprehensive Older Americans Act Amendments of 1978." The signing of the bill was significant for the Indian community because it represented seven years of persistent advocacy. It meant that now, under the Older Americans Act, Indian tribes could receive funding directly from the federal government, rather than through the state units on aging or area agencies.

In reviewing the history of legislation on aging that led to the 1978 amendments, Effman explained that the original 1965 Older Americans Act established the Administration on Aging and grants to states for their aging programs. This legislation did not consider the incorporation of the Indian community into the context of the law. Indian tribes had not been considered as entities that needed special treatment because the development of Indian tribal sovereignty issues had not, as yet, reached the prominence it has now.

In 1977, a year before the national focus on the 1978 amendments to the Older Americans Act was scheduled, the National Indian Council on Aging opened its Washington, D.C. liaison office. Its specific purpose was to provide sensitivity and information regarding the needs of the American Indian elderly. This also included meeting with members of the Congressional delegation to persuade them to develop a sound piece of legislation that would benefit the Indian elderly and be culturally sensitive to the needs of the Indian community.

These efforts were instrumental in securing passage of the "Comprehensive Older Americans Act Amendments of 1978," especially with Title VI, "Grants for Indian Tribes." This title introduces the concept of "direct funding" into the Act. It will be administered by the Administration on Aging, which will issue grant awards to those Indian tribes which meet the minimum criteria established by the Commissioner.

Briefly, Indian tribes are eligible for assistance under this title only if:

(1) the tribal organization represents at least 75 individuals who are 60 years of age or older;

(2) the tribal organization demonstrates the ability to deliver social services, including nutritional services; and

(3) individuals to be served by the tribal organization will not receive services under Title III of the Act during the year for which application under this title is made.

In addition, eligible tribal organizations must submit an application to the Commissioner which meets the minimum criteria set forth in the regulations. Among others, applications must meet the following requirements: (a) provide that the eligible tribal organization will evaluate the need for social and nutritional services among the older Indians; (b) provide proper administration and accountability; (c) provide for a means of periodic evaluation from an outside source; (d) insure proper access to the services provided; (e) provide for nutritional services to the elderly, and (f) provide a preference for Indians aged 60 and older for full- or part-time staff positions wherever feasible.

Following the reports on the legislation and the history of the aging program, there was a brief question and answer session in which workshop participants asked Dr. C.S. Stitt questions on regulations relating to non-Indian spouses, health facilities construction, Medicare and Medicaid reimbursements, and nutrition programs.

PATIENT RIGHTS

Moderator: Carl Cameron, Deputy Director, Inter-tribal Council of Michigan

Facilitators: Elliot Booth, Tribal Health Coordinator, Colorado River Tribe
Ademla Pedro, Patient Representative, Phoenix Service Unit, Indian Health Board

The session began with a discussion on patient grievance procedures. In 1975 it became evident that a "Patient Bill of Rights" was merely a piece of paper without an effective enforcement mechanism. Several approaches were used in an attempt to develop a system to allow for patient representation. Those approaches and their limitations included:

In-House IHS Mechanism — these are generally feared by patients. Indications are that "loyalty" lies with protecting the system. IHS staff have other responsibilities and cannot devote the necessary time to resolve patient problems. A fear of reprisal by medical staff and not knowing who to talk with about a situation are other drawbacks with this approach.

Health Boards — Boards often do not have trained staff. Accessibility is usually limited to monthly Board meetings, and patients are sometimes confused as to the role of various health boards. The major difficulty has been the delay and uncertainty of action under these circumstances.

Committees — Committees generally encounter the same basic problems as health boards.

Due to these and other problems encountered, efforts were made to devise a new approach which would: insure patients rights; decrease medical staff and patient frustration due to language barriers; provide insight into the cause of communication and services breakdown, and link patients, health boards and IHS into a process for the improvement of Indian health care.

As part of this effort the Phoenix Service Unit Indian Health Advisory Board began a series of meetings with the Director of the Phoenix Indian Medical Center and other administrative staff to discuss the problem areas and to develop a new approach to solving problems related to patient representation.

As a result of these meetings the Phoenix Service Unit Health Board now sponsors a Patient Representative Program in the Phoenix Indian Medical Center. This program did not develop with a great deal of ease; it took some innovative processes to get the program to its present level.

The Phoenix program utilizes Community Health Representatives (CHR) and has developed training courses through the use of IHS personnel, such as mental health, social service and medical staff. The Phoenix board has had a positive experience with their program, and they feel that it

has established credibility and is looked at as an asset to the Phoenix Indian Medical Center.

Various service units are in the process of developing or have completed a Patient Bill of Rights. This is an important document that will assist the patient and IHS staff toward improved patient care.

The workshop concluded with recommendations that all service units and health boards establish a Patient Bill of Rights. Depending on the size of an IHS facility and workload, perhaps certain CHR's could carry out patient representation responsibilities. Indian organizations that desire patient representatives will have to be innovative in establishing and funding such positions. Chances for IHS positions being used for this purpose at present are doubtful. Contract medical facilities with a sizable number of Indian patients might better utilize patient representatives.

TITLE XX OF THE SOCIAL SECURITY ACT/INDIAN CHILD WELFARE ACT

Moderator: Linda Lejero, NIHB Representative, Tucson area

Facilitators: John Lewis, Executive Director, Inter-tribal Council of Arizona
Goldie Denny, Director of Social Services, Quinault Tribe
John Kelly, Attorney
John Powless, NIHB Deputy Director

John Lewis began the workshop presentation by stating that Title XX is a resource for social services to states. He stated that we are finding social services and health services go hand in hand in many instances. Title XX provides states with resources to plan and implement social service programs.

Lewis explained that the Indian populus nationwide falls into "high risk" categories. For example, 65 percent of the Native American population are elderly, children, unemployed, or have incomes under $5,000. Title XX funds need to be used to meet the needs of these people, he said.

Lewis then gave some examples of the problems tribes in Arizona have had in trying to utilize Title XX funds. One common problem that Indian tribes have is being left out of the state planning process. When state officials plan for health needs, their priorities often differ from tribes'.

Another problem in Arizona and other states is related to jurisdiction. For example, the states' inability to set standards for various programs and facilities limits services on reservations.

In an attempt to deal with these and other problems an amendment to Title XX has been developed to encourage direct funding to tribes, Lewis said. This recommendation is consistent with the effort of Tribal Self-Determination and has been taken to non-Indian groups and organizations for their support. At the present time there has been no response on the report.

Goldie Denny led off the discussion of the Indian Child Welfare Act by stating that some of the problems with law pertain to jurisdiction and lack of funding to tribes. She said that the Indian Child Welfare Act and Title XX tie together because of the Indian family's involvement in social services. If there is disruption in a family involving a child, the family usually needs other social services to help them stabilize.

Affirmative action is necessary to insure placing the child in an Indian setting before placing him/her elsewhere. A problem here is a conflict with the state over "proper" family living. The state will often rely on a Child Welfare Specialist who isn't necessarily an Indian to determine whether or not the home is adequate based on material standards (i.e., square footage per person, number of rooms, number of beds) and not the quality of nurturing and love the child would receive. The regulations need to be clearer in this regard, Denny said.

A major drawback of the Act is that it doesn't set aside funds for tribes to litigate cases and develop child welfare programs and procedures. This is an important point for effective implementation of the intent of the Act.

John Kelly covered the legal aspects of P.L. 95-608. He said the law addresses foster care, termination of parental rights, pre-adoptive placement, and adoption. The Act defines two kinds of jurisdiction: (1) exclusive jurisdiction, where the tribe has jurisdiction over reservation children, and (2) preferred or concurrent jurisdiction, where the state court must notify the parents, the tribe or closest tribal office, when dealing in any welfare case of an Indian child.

Kelly stated the regulations are not clear on the definition of residency or domicilary. At this point, the definition will probably be interpreted by the state court.

Under the law, the state has the responsibility to determine whether the Indian child is from a federally-recognized tribe, and communicate or give notice to the tribe, natural parents, and custodians about the transfer of jurisdiction to tribal court. If the state will not transfer jurisdiction, Kelly said there is a requirement in the Act on how the state must deal with the Indian child.

URBAN INDIAN HEALTH CARE

Moderator: Gerald Ivey, Director, Alaska Native Health Service

Facilitator: Luana Reyes, Chairperson, American Indian Health Care Association

Co-facilitators: Dr. Lionel DeMontigny, Director, IHS Community Development
Don Donaldson, IHS Community Development

The Urban Indian Health Care workshops were presented to review and discuss pertinent national level issues that affect Urban Indians both directly and indirectly. Urban and tribal input are necessary to obtain a comprehensive health program that offers quality services to American Indians and Alaska Natives.

With this objective in mind, many of the following recommendations were discussed, with a group consensus that they be brought to the attention and consideration of the Third Annual Indian/Alaska Native Conference attendees for further analysis and action:

1. That Congress appropriate the full funding authorized under P.L. 94-437, Title V, to enable the establishment, continued operation and/or expansion of urban Indian health programs.
2. That IHS contract health services regulations be revised to include eligibility for contract care services to all Indians regardless of place of residence, and that funding be increased to provide services to all urban Indians.
3. That urban Indian populations receive priority consideration for National Health Service Corps (NHSC) assignees.
4. That existing service providers (including local health departments and NHSC service sites) establish satellite out-patient clinics in areas with significant concentrations of urban Indians and that policy boards comprised of urban Indians be formed to provide input on services.
5. That direct funding through Titles V (maternal and child health) and X (family planning) of the Public Health Service Act be made available to urban Indian health programs. The current method of allocating funds through states to local agencies often results in statewide operated programs and/or funding to existing agencies which are often inaccessible to urban Indian populations.
6. That funding be made available for Indian-operated advocacy, outreach, transportation and other supportive services to facilitate access to existing services for urban Indians. Further, that existing service agencies be required to employ Indian people to provide these services where direct Indian-operated services are not available.
7. That funding under P.L. 94-437, Title I Section 102 be increased to facilitate the development of Indian Health and allied-health professionals and that funding be allocated on a more equitable basis (i.e. priority consideration for tribal/urban programs and geographic distribution). Further, that urban Indian programs receive priority consideration for funding under Section 787 of the PHS Act, Health Career Opportunity Programs.

Discussion also focused on suggested amendments to P.L. 94-437, the Indian Health Care Improvement Act. Concensus of the workshop was that Title V authorization be extended through 1984 and that a specific title be added to address the concerns of rural Indian Health problems.

Considerable discussion was held concerning the IHS requirement that Indian organizations be controlled by Indians and that all Board members must be Indian. Examples were cited where some funding agencies will not give funds to groups that are not representative of the community at large; that is, board membership must be open to all clients and not restricted to Indian membership only. The group recommended that this issue be studied to determine the feasibility of allowing Indian organizations to decide what constitutes Indian ownership and whether or not they want non-Indian representation on their Board.

The population issue (i.e. the requirement to use 1970 census figures) should be addressed so that the Urban Specific Health Plan (a 4 year plan based on an under counted population) can be updated when more accurate information is available from the 1980 census.

Lastly, the issue of composition of Boards of Directors for urban health programs was discussed, but no consensus was reached. It is an issue that needs further attention.

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DR. ROBERT BIRCH; IHS P.L. 94-437 Project Director, reviews procedures for developing IHS "National Plan" on the progress and expenditures of the Indian Health Improvement Act. Felicia Hodge (left), executive director of the Northwest Portland Area Indian Health Board, served as moderator for the workshop.

RECOMMENDED CHANGES AND/OR ADDITIONS TO IMPROVE P.L. 94-437

Moderator: Felicia Hodge, Executive Director, Northwest Portland Area Indian Health Board

Facilitator: Dr.Robert Birch, IHS P.L. 94-437 Project Coordinator

Dr. Birch talked about the objectives of the workshop and the procedures for making recommendations. He discussed the development of P.L. 94-437, the vital role of Indian participation in the development and planning and operation of P.L. 94-437, and the role of the National Indian Organizations (NIHB, NCAI, NTCA, AIHCA) consultants to IHS for P.L. 94-437.

Dr. Birch also discussed briefly the importance of the Secretary's recommendations to the Congress for F.Y. 1981-1984, and that the IHS submission of the Comprehensive Health Plan for American Indian and Alaskan Native people for Fiscal Year 1981-1984 (National Plan) will be based on Tribal and Urban Specific Health Plans (T/USHP).

He explained the T/USHP process and the consolidation into the National Plan. Among others, the following recommendations were presented at the workshop sessions to change P.L. 94-437:

1. The same cycles for scholarship announcements be the same date.
2. Have an open and continuous application announcement with no submission deadlines.
3. Implement Indian health professionals in educational programs as role models to Indian students.
4. Include higher authorization levels of P.L. 94-437 for F.Y. 1981-1984.
5. A mechanism be developed to allow for more local control for implementation of all sections of Title 1 under P.L. 94-437.
6. Contract Health Service be extended to urban Indians only if more money is appropriated to cover reservation Indian health care because there is not enough money to address the present needs for reservation Indians.
7. Continue to support the development of an American Indian School of Medicine.
8. To include in P.L. 94-437, in regard to diabetes, that something be done at the national, state, and local level regarding preventative treatment and research, and for establishing programs in nutrition and diet in order to overcome this severe health problem. Also, to establish five more model programs for the treatment and control of diabetes.
9. Develop more explicit definitions of "preparatory scholarship" and "professional scholarship" under Title I.
10. Improve coordination of the P.L. 94-437 scholarship program so that medical students will not have to suffer the inconveniences of delayed payments.
11. Increase efforts to obtain Medicaid and Medicare reimbursements from states under Title IV of P.L. 94-437.
12. Increase tribal involvement in the development of the IHS National Plan on the progress of P.L. 94-437.

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Banquet

JOSEPH DE LA CRUZ: This is the first national Indian Alaska/Native health conference I've had an opportunity to attend. I am very impressed and I understand you had an excellent salmon barbecue last night and the people who are responsible multiplied their three salmon and their five loaves of bread to feed about 3,500 people. I hope everyone had a good meal. The salmon and the seafood went far enough because I understand that some of our people from different parts of the country don't eat salmon and everything went fine — doggone it.

I stopped in on some of the workshops and looking at the agenda, I would like to make some welcoming remarks. Realizing how far we've come in Indian health in the last decade, and how much more work we have to do, there are some things that really concern me that at times I don't feel that we pay enough attention to. I think as Indian people we all realize that all things are related. Last year I had the opportunity to hear two very important people in this nation talk about national Indian health planning. It came to my mind that that is something that Indian people have always recognized as a right, the right of people to good health care. With all the things that tribal governments have to deal with, it seems like we spend most of our time looking at programs, funding and regulations that come after we lobby them. We've got several national Indian organizations in various areas. I have yet to see when we have been able to pull together and really lay out some of the political strategy, whether it be in social services, health, rights issues, or what. When I looked at the people that never wanted to come over that hill, and the people here at this banquet, we have a problem that just that many telegrams could be sent to the appropriate people. That type of action could move some of the things that we spend days and days to deliberate at conferences and with tribal councils at home.

I really do think that eventually there is going to be a national health plan — when I heard President Carter deliver his message in Memphis last December, and Senator Kennedy eventually write that we are going to have a national health plan — when that plan comes about, I wonder where our Indian health programs are going to be. Are we going to be lumped in with everyone else in the nation? Things that we try to keep from happening almost in every area where we have some specific trust relationship with the United States government; and a lot of means that we go through, I don't see people addressing things like that or trying to look down the road to the future of: What trail do we want to follow? What should we be working on when that day comes? So that we can collectively pull our forces together and lobby and come up with something that we worked for toward the future of the Indian people not only with Indian Health, but within the Bureau of Indian Affairs, and some of these transitions.

Today, people are beginning to look at the different types of management systems. They are looking at data on Indian people of all kinds. To my knowledge to this day, there hasn't been a lot of improvement in the discussion of those management information systems. I don't know how many tribal people are working in the health field or areas that the Bureau of Indian Affairs deals with or who are developing management systems are really taking a good look at what is being designed and put together.

Is that data something that is going to be beneficial to you as Indian people and your tribes? Or is it something that is going to be designed to perpetuate some of the things that have been happening for the last two hundred years? I think that our Indian leaders, our Indian technical people, better review the stuff that is coming out of the different areas in the Bureau of Indian Affairs on management information systems. I don't believe what they are putting together without our input is something that is going to benefit us.

There is a management information system in Indian Health Service that's been in existence for quite some time. I think it would be a good question to ask: Does that system provide the information that we need as Indian people to work and coordinate things with the Indian Health Service; to really see about some of the statistics that we keep talking and hearing about, to really start to make some major changes. Until we start analyzing those things, we are going to be reviewing programs, some of them that we collectively lobbied, and we try to get our input into regulations. And most of the time the input of Indian people or technical people who are Indians is completely ignored. You have a day-and-a-half left of this conference, I hope that leaves you with some things to think about and some questions to raise.

We are fortunate that from some regions of this country we have got some strong tribal followings concerned about Indian health and I would like to introduce those here from the Oklahoma area first. We've got Oklahoma tribal leaders and members of the Oklahoma Area Indian Health Board, I would like you to stand up. John Sloat, Governor, Absentee Shawnee Tribe; Henry Secondine, Chairman of the Delaware Tribe, Eastern Oklahoma; Larry Snake, President of the Delaware Tribe, Western Oklahoma; Edgar French, Vice-President of the Delaware Tribe, Western Oklahoma; Joe Mehojah, Chairman of the Kaw Tribe; Elmer Grant, Chief, Sac and Fox Tribe

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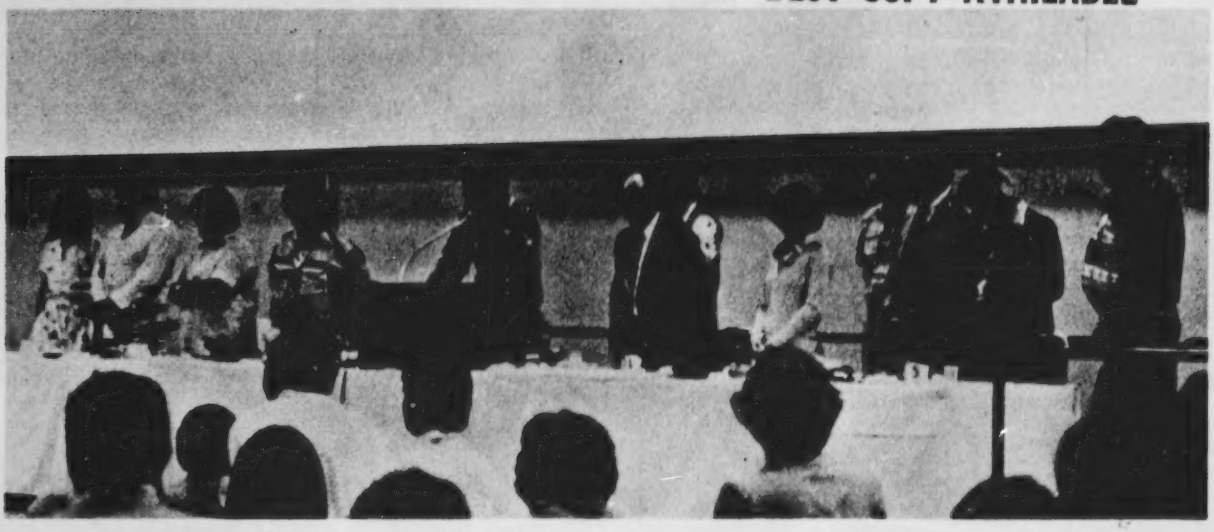

PARTICIPANTS AT TUESDAY night's banquet take moment for invocation. Dr. Everett Rhoades (right of podium) was the guest speaker for the evening.

of Oklahoma; Henry Allen, Chairman of the Tonkawa Tribe; and Virgil Franklin, Councilman of the Cheyenne-Arapahoe.

Now, from the Northwest, I would also like to introduce: from Yakima, the Vice-Chairman of the Yakima Tribe, Johnson Meninick, and with him is Councilman Yallup, Russell Jim — I want to apologize, I have been a little rude from the way I grew up, I should have introduced these people first. My father, Roger Jim and my grandfather, Leonard Tomaskin. Also I noticed at this conference, the Vice-Chairman of the Siletz Tribe, which was brought back into federal recognition, just a few years ago, and they came a long way through their activity, participation, and organization, Pauline Ricks plese stand up. Gilbert Teton, Fort Hall; Cal Peters, Squaxin Island. I didn't prepare a list, but if there are any more tribal chairmen please stand up. I would like to have the people at this banquet give a big hand to the tribal leaders who participate in organizations like the National Indian Health Board. These are the people who really make it work.

I would like to ask the Chairman of the Northwest Portland Area Indian Health Board, Mel Sampson, to introduce the National Indian Health Board members.

MEL SAMPSON: In making these introductions, I would like all of the board members, plus all of the people from the same respective areas to also rise. We will start out with our Vice-Chairman of the National Indian Health Board — and you will note as these people are introduced — we are not partial as to whether they are female or whether they be male, as long as they are Indian or Alaskan Native — slipped that in there.

I would like to start out with Alaska, Ethel Gonzales, who is the Vice-Chairman of the National Indian Health Board, representing the Alaska natives. If all the people from Alaska would please rise. From the great southwest area that we are familiar with, one of our Indian headquarters operations from Albuquerque, George Platero. Would you and your — have you ever seen a Navajo stand up alone before? Protecting us on our west coast and the longest state in the union, our Indian territory from California, Timm Williams and all of your Californians, please rise. From the part of the country that possesses a good share of the water that's left here, from the water territory of Bemidji, Don LaPointe, and all of your Chippewas and what have you. From the great area of Montana, the Billings area, Daniel Foote and all of you Blackfeet and whatever is left in Montana, please rise.

Now, down in the central southwest area, the area that is noted for a tremendous amount of Indians, the people from Oklahoma stand up, Larry Snake. Coming from down in an area that is called the United Southeastern Tribes, is an organization that represents all of our eastern tribes from New York clear down to Florida, we have the Chairman of the National Indian Health Board, Howard Tommie. From the extreme southwest area, Linda Lejero from Tucson.

As most of you have experienced in the past and most of you know that Navajos always seem to get in there more than once; the situation not being any different here. From the great Indian nation of the Navajos, Elwood Saganey and all the Navajos.

Representing down in the hot part of the country where the lizards and rattlesnakes prevail — where their source of industry is raising

sagebrush — Billy Kane, and all the people from the Phoenix area. Of course, our host being of the Portland area and myself — if we have anyone from the Portland, please rise.

JOSEPH DE LA CRUZ: Next, it is my privilege to introduce the members of the head table, even though Mel has already introduced some of them. From my far left is Howard Tommie, on the other side is John Powless. Dr. Stitt, the area director of the Portland area; Dr. Marlene Haffner, area director from the Navajo area. Of course, you know Mel Sampson. Next to Mel is Joe Jay Pinkham, Councilman from the Yakima Nation; next to Joe Jay is Tallulah Pinkham — his beautiful wife and guidance. Next to Tallulah is Dr. Lionel deMontigney from the IHS headquarters.

Next, again, I call on Mel Sampson to give the Profile.

MEL SAMPSON: One of the unfortunate things I have an opportunity to present because of the circumstance that caused it to arise, and the National Indian Health Board took the opportunity and courage with the greatest sincereness to have this banquet in recognition and in honor of a person who was a Yakima tribal member, who represented all the Indians throughout the United States and Alaska, who passed away in a tragic automobile accident in March. She was the late Miss Margaret "Maggie" Lovie Pinkham. I would like to, if I may, read an excerpt about Maggie.

Grief was in the heart of the Yakima Nation and across the Indian country with the announcement of Margaret Pinkham's death on March 31st when she was killed in an early morning automobile accident at the age of twenty. Margaret was born on July 21st, 1958, to Tallulah and Joe Jay Pinkham. She graduated in 1976 and had attended the Institute of American Indian Arts in Santa Fe, New Mexico, where she received her Associate of Fine Arts Degree in photography. While attending, she carried the title of Miss Southwest. She was selected Miss Yakima Number Nine in 1978. She entered the Miss Indian America Pageant in Sheridan, Wyoming, where she became the first alternate of Miss Indian America Number Twenty-five, Susan M. Arkeketa on July 30. During the 35th Annual Conference of the National Congress of American Indians, Margaret was selected from a field of 12 contestants by five judges on September 20, in Rapid City, South Dakota; she was the second Miss Yakima Nation to become Miss NCAI. Other titles she had held are: the Invitational Basketball Tournament Queen in 1976; the third runner-up in Miss NCAI; top Miss Junior Miss in 1976; and the princess for the Pow-Wow on Veteran's Day. Her high school achievements included — but were not limited to — the Letterman's Club vice-president; the Indian Club president, the Annual Photographer of the Annual and Spirit Club. She was also an ardent participant in such sports as volleyball, basketball, softball, and a member of the Girl's Athletic Association and the Tennis team.

In 1976 she entered the National All-Indian Tennis Championships in San Diego, where she placed second in the national finals. Maggie was a member of the Satus Longhouse, where she was very active. Margaret is survived by her parents, Joe Jay and Tallulah Pinkham; three brothers; Joe Jay Pinkham, III, Glen Pinkham, and Sandy Pinkham, all adopted; three sisters, Ida Joe Birges of Lawrence, Kansas; Norma Pinkham, now attending college in Oklahoma, and Judy Pinkham.

It has been said by all who knew Maggie that she represented the Yakima Indian Nation well. In the pageant she was a good representative of all Indian people. In concluding and to give you a better insight of what Maggie Pinkham was all about, she wrote an essay to the U.S. government on tribal needs. I would like to quote a paragraph from her essay.

"We welcomed you, the orphan children of the European and English backlash of religious freedoms and the pursuit of happiness, the Indian people of the true world of sharing and respect for nature and the right to survival and non-abuse. We shared our food; we gave you shelted; we nursed your sick, and we clothed your weary bodies. Yet, now that you have reached your adulthood and have grown strong, you are ready to shove me aside and put me in a rest home with the hope that I will not give you cause to worry and slowly wither away and give up and die, as you have done to your own elderly."

In recognition of Maggie, we will proceed with a short giveaway type of ceremony that's in conjunction with the continuance of our thoughts and what Maggie would have liked us to do, which we will do. So at this time I would like to introduce Maggie's mother, Mrs. Pinkham, and her father, Joe Jay Pinkham.

JOHN POWLESS: At this time we have a number of shawls to give away. Please come forward when I read the list and receive your shawl. The first person we would like to call up is Marilyn Bonney, Miss Indian U.S.A. The next person is Colleen Frilander, Miss Colville Confederated Tribes. Next we would like to call Juanita Kelly, Miss Lummi Nation. Next we would like to call Dena Starr. Next is Marina Guterrez, Miss Spokane. Next we would like to invite up Maria Si John, first runner-up of Miss Spokane. In honor of Maggie and in appreciation for their services at this conference, Felicia Hodge. Next we would like to invite up Trudy Ware. We would like to invite up Violet Hillaire. She was responsible for the organization of the salmon bake and we would like to extend our thanks for all the effort she put forth in that. We would like to present the final shawl to Tallulah Pinkham.

I have a little note here I would like to read before the next presentation is made by Mel. It states: "We from this area are most honored and proud to have hosted this convention. We are

fortunate to have interested people helping us and to have such a good area health staff, directed by Felicia Hodge. We would like to present this small gift of appreciation to Felicia Hodge."

Before we conclude this ceremony, I would just like to say I hope these Indian women that we've honored tonight continue to extend their services in the Indian community and assisting Indian people and especially the young princesses, whom we honored tonight, I hope they will remember this night as long as they live and remember how committed Maggie Pinkham was to the American Indian people.

JOSEPH DE LA CRUZ: It was a beautiful thing that was just done here and many of us in our respective areas, where we live, have tragedies such as what happened to Maggie. I think people often wonder how to handle this and we've observed sometimes some of these things crush really strong people. It was my pleasure to know Maggie and is my pleasure to be a very close friend of Joe Jay and Tallulah Pinkham. One thing that I keep in mind and I observe when things like this happen, is that our people still stick with their strong traditions and religious beliefs and are able to accept and understand and handle these things better than any other people. The young princesses who received the shawls have been presented with an inspiration of the things that lie ahead of you in your young lives.

It is an honor and pleasure to introduce our speaker, who is a man of many things. First of all, he's an Indian. He's a member of the Kiowa Tribal Council. It was early in this man's life that he dedicated his life to people. He was the founder of the Association of American Indian Physicians and is Professor of Medicine and Microbiology at the University of Oklahoma Medical Center. He's had a distinguished career in the area of health. As I look back through his career, he served in the health fields that were a must and a need to get better health services to the Indian people. He served on many boards. Among his many other board and committee memberships, he has served on the Area Health Advisory Board. He's served on several national task forces.

What I think most of this man is he is a true medicine man. With his Indian background, he has a complete understanding and knowledge of the political ramifications that we have to go through. He has dedicated his entire lifetime to understand the technologies — as you look at his resume — and it must be very sad for him to see the modern technical things that are not reaching his own people. It is a deep honor for me to introduce to you tonight Dr. Everett Rhoades, Councilman from the Kiowa Tribe.

DR. EVERETT RHOADES: I'm a Kiowa Indian and not afraid of any man, a couple of women, yes. I am touched by the very kind introduction. I was going to say something about Joe, but he was so kind in his introduction, I can't say it now; even though, it is kind of true. I don't have anything to say. I have been sitting up here exchanging ideas with Joe and now my mind is completely blank. I'm also humble. Perhaps, like Prime Minister Clement Atlee of whom Winston Churchill said, "Mr. Atlee is a very modest man with a great deal to be modest about."

I find that it is indeed a very great honor for me — among the greatest that I have had — to be in the presence of the distinguished people at this meeting. Some of the individuals, it is my privilege to be able to associate with here have already been introduced, Howard Tommie, Mel Sampson, Dr. H. C. Townsley; in the audience; Luane Reyes, director of the Seattle Indian Health Board; Charlie Deegan, Dr. deMontigney, John Belindo, an extraordinary dear, special friend and brother to me; Bernie Kahrahra, Dr. Ralph Dru. Many individuals here have already become legendary in their own time and have seen about the requirements that have permitted us to progress as far as having this great conference that you have all been so active in. I want to thank those of you who asked me to appear on this distinguished program; I'm not sure why I was asked. The last time I spoke before the National Indian Health Board the score was something like Board 10 and Rhoades 0.

One of the things I am going to talk about is paranoia — and paranoia is being asked to speak in front of the National Indian Health Board. I said to John, "I'm not sure why you all wanted me to come and talk. You know, there are some people around that really hate me." And John said, "No, Everett, I assure you that's not really true. As a matter of fact if there are any differences that you might have or have had, I want to assure you that the board is going to ask you to come and speak tonight and as a way of doing that, they are going to bury the hatchet." And I said, "Yes, in my head." Except as you can see, that's already been done. Then I said to myself, "Damn! Maybe they want me to explain Bill Wilson." I want everybody to know that I am not responsible for Bill Wilson; no one is, not even himself.

I wanted to talk with you about some perspectives about Indian living from the standpoint of health and medicine that constitute what I think represents a great contradiction of Indian life. Some of you have heard me say before and I know you live every day that everything that an Indian person does is a contradiction. And I would like to explain to you what I mean by that and why I think it's important and why I think it's appropriate to think about it at your conference today and in the days to come.

In 1876, an inconspicuous little event closed the door on an ancient era and launched a movement in science and medicine that has not yet run its course. This event not only changed people's lives, but changed the way that many

people in the western hemisphere at least, regard life, health and disease.

The event which I am talking about was a letter that was sent by an obscure German general practitioner named Robert Koch. He sent this letter to his old professor, Ferdinand Cohn, explaining that he had discovered a bacterium that was the cause of anthrax.

This event drove the final wedge between older, ancient concepts of disease and modern scientific or "western" medicine. Some of these questions were about the nature of disease; what causes the disease; what is death? And finally, what is health?

Perhaps you might be interested just parenthetically to know some of the other events which occurred in the fateful year of 1876. In that year occurred the most contested presidential election ever held in the United States. That year a Democrat, Samuel Tilden, received a majority of the popular votes cast in a general election over Rutherford B. Hayes, a Republican. However, there were four states in which the election was contested: Oregon, Florida, Louisiana, and South Carolina. Without these states, Tilden was one electoral vote short of election. The contest was thrown into Congress with the result that Hayes could receive fewer votes and was declared President. A great deal of tribal politics springs from that era of political behavior as you can see.

Some of the other events that took place that year were: Colorado was admitted to the Union as the Centennial State; the National Baseball League was founded; the telephone patent was given to Alexander Graham Bell; and the publication of "The Adventures of Tom Sawyer." I would be interested in a show of hands of people who know what I am thinking about the greatest event for Indian people that occurred in 1876? I am sure if I gave the date of June 25th, that many of you would be aware. I am very happy that it's in the history books of key facts. That's the anniversary of the date that "Custer died for your sins." I am still not sure what that means, but I am going to quote it every chance I get. I think Custer probably died for his own sins more than for the sins of others. Now, let's get back to the original story.

Prior to Koch's time ideas about health and disease were really few in number, and remarkably similar to those of the American Indians at the present time. The ancient Assyrians seemed to believe that disease resulted from divine punishment. On the other hand, the Greeks introduced the idea of impurity of contamination as representing disease. Alceon of Croton claimed that disease was a disturbance of the "symmetron," which was the health of man. Disease was a lack of harmony with the "physic" of the patient. Where have you heard disease described that way before? I hardly need to point out that this view is precisely that of the American Indian, especially since "symmetry" is just another way of saying "harmony."

As time went by, following the Greek inquiry, people began to investigate the nature of disease — began to produce observations that caused a gradual erosion of the idea of harmony as representing health. It is ironic that this began with the Greeks. Hippocrates himself, considered the father of modern medicine, made astute observations as to disease processes and manifestations in sick individuals. Scholars came to think about disease in terms of anatomy and physiology; that is, in terms of structure and function of the body and its parts. The application of observations to groups of patients was made by a man named Thomas Sydenham, who applied the inductive scientific principle to medicine — laying the basis for predictability which is the hallmark of science.

Another current in the stream of knowledge about disease and health related to concerns about the *cause*, or etiology, of disease. Other causes than disturbance of harmony became obvious. Fracetoria in 1546 published a monogram containing a poem entitled "Syphilis" — the French disease. This description and naming of syphilis was also a treatise on the etiology of syphilis as a contagious disease — spreading from individual to individual, opening the wedge a little bit further between earlier concepts of health and disease. This and several other lines of science converged to produce the report by Koch.

Lange, in the early 1600's, introduced the idea of a "pathologia animatum," in which he expressed the idea that a disease could be caused by the entry into an individual of small living things. Lavoisier, in the mid-1700's, introduced chemistry into the thinking of medicine by showing the participation of molecular oxygen being responsible for combustion. It is of interest that Koch's great colleague and rival in France — who is more well-known — the great Louis Pasteur, was not a physician at all, but a chemist. All of these things had progressed to such a point that by the late 1700's the sciences of learning were so popular and advanced that this period is actually known as the Age of Enlightenment, or the Age of Reason in history. And it was associated with what was by now an irrevocable break in modern scientific humanism and the older, ancient concepts, which we sometimes call primitive.

Man came to regard himself, at least in Europe and America, as the highest achievement of creation. Man was above all other things, living or dead; an end in himself. It became clear to these people that God undoubtedly created the world for man and his pleasure. All the supposed (and actually nonexistent) rights of man, spring from this period. You see, if you assume that man is the ultimate, then of course, you can declare that man has all kinds of rights. And all kinds of injustices can be performed in the names of these rights. I am happy to say that in this country the one group of people who are totally steadfast against that erroneous vision of man in the universe is the

American Indian. The actual danger of extinction of the world and of man that we are presently faced with is the natural result of this Judeo-Christian Western European-American philosophy under whose aegis we have declared our right to rape the earth. That is the subject of another speech.

The development almost immediately of the field of bacteriology by Koch and Pasteur and of students marked a further turning point away from the old ideas; a point at which there was not turning back. Koch's ideas were actually codified into scientific principles called Koch's Postulates, which set out the conditions in which a given bacterium could be determined to be the cause of an illness. Koch's Postulates define an important and subtle tenet of scientific philosophy: True scientific method does not consist in proving that a given hypothesis is true; but more importantly, in excluding all the possible explanations but one for a given event. To the scientist then, truth is defined as that hypothesis which best explains all observable data. Sometimes a hypothesis is simply a guess, and since not all data can be observable, you can see that this is a shallow, sterile viewpoint of truth. Indeed it has been accepted for a long time that science cannot prove ultimate causality. There is always that remaining question about what is the cause of disease.

In contrast to this new development of this scientific humanism that I've described, let me tell you about a recent experience I had in my own practice at the University of Oklahoma Health Science Center. I encountered a patient who was 26 years old, an Indian man, whom I was asked to see because he was so withdrawn and non-communicative. He had a very peculiar illness. He had a great big sore on his leg which would not heal up. All of the expert scientists in the hospital could not agree on the nature of this ulcer. Some said it was a malignancy, others said their investigation under the microscope suggested it was not a malignancy. In any case, the patient was far more ill than the simple ulcer on his leg would indicate.

I was struck by the fact that behind his apparent stoicism was a patient absolutely terrified and depressed. He knew precisely what was wrong with him. He had a half sister with whom he had intermittently lived; who had actually put a curse on him; the result of which, he would die. We worked with him and worked with him. To the best of my knowledge, we have a very, very powerful Kiowa medicine man who I was absolutely sure would be stronger than the curse that was put on this young man. But he chose not to see a Kiowa medicine man. I became busy with other activities in the hospital, and didn't see him for a couple of weeks. I was told, "Oh, had you not heard? His half sister came to take him home and he died the following week and an autopsy was refused."

I cite this case to illustrate the absolute opposite nature of Indian and "scientific" medicine. Many non-Indian physicians are startled to learn that there is a great infrastructure in the community of disease and healing by Indians, even in the state of Oklahoma that is absolutely incomprehensible to scientific methodology. There are forces and powers that are possessed by Indian people that I was fortunately aware of before I went into western medicine. These forces are capable of killing and capable of healing and science cannot deal with them at all — at least at the present time. I have found it of interest that in viewing the statistics that the causes of death within the Indian Health Service itself that six to eight per cent of Indians that die within IHS are coded out in the diagnosis book as "poorly defined conditions and syndromes."

What then is the nature of traditional Indian medicine? Actually, Indian medicine consists of a very complex composite of all sorts of skills from simple hygiene and first aid to much more complicated knowledge of anatomy and function that I was aware of. The Kiowa's language, for example, has separate names for each knuckle joint in the hands and in the feet. There was a name for the depression in the lip under the nose. These kinds of precise anatomical definitions could only

have been obtained by very precise, minute knowledge and understanding of form and function and really represent refined concepts of structure and function.

My grandmother, who died when I was very small, used to feed my older sister when she was an infant by chewing hardtack until it was partially digested. Then she would put the hardtack into my sister's mouth. And it's only been in recent times that we've understood the lack of development of enzymes for digestion in small infants. So that it made a certain kind of physiological sense to feed infants that way by partially digesting their food. There are many, many other examples of this. The Kiowas used to go up north and climb a certain kind of evergreen tree to get a resin they used as a toothpaste — fascinating. There are many other examples of this rather ingenuous attraction to small details of health.

The central basis of much of Indian medicine can best be described in terms of magic — meaning that we do not understand it according to the usual laws of nature. It is this element of magic which cannot be accepted by the average non-Indian. This concept of disease and health depends upon concepts much older and perhaps better established than those produced by science, which really only represents a relatively recent development.

Modern science is preoccupied with failure of an organ as the basic disease process. Here lies one of the fundamental divergents of Indian and non-Indian health. To the non-Indian, health is not real; health is a symbolic term that describes the absence of disease. It is the disease which is real to the non-Indian, not health. On the other hand, to the Indian it's health, not disease, that's real.

Now, we have already mentioned the similarity in concepts between the Greeks and Indians in which there is an active harmony or symmetron which describes health. Disease is an absence of harmony, symmetry, or beauty. Obviously, the Indian concept is a much more vital and meaningful way to describe health. It also permits a more constructive approach to healing. The non-Indian scientist thinks in terms of supporting or replacing a defective organ; much as one would a carburetor on an automobile. It is in a way unfortunate that the psychiatrists have been the ones most interested in Indian health; although, I give them credit for that. Because this interest by the psychiatrists has prompted the too limited view, that Indian medicine is just a kind of red man's psychiatry. The trouble with this view is that it is insufficient to encompass all of what Indian medicine really is.

Indian medicine is psychiatric to a large degree, but it is much more than psychiatric — perhaps, it might be best described as metapsychiatric, going beyond psychiatry. Indeed, what I know of modern Indian medicine men is that they are true psychosomaticists.

There is a prevalent attitude among many that scientific medicine evolved out of, and runs parallel to, Indian or "primitive" medicine. Ackerknecht, one of the greatest medical historians, was the first to emphasize that this is not true. Quite the contrary — neither discipline will ever merge with the other. They are diametrically opposite. They will not come together; one did not evolve out of the other. In fact, they are contradictory; they are opposed. Each stands on its own.

I think this consideration might be given to the recommendation that I've heard expressed that, perhaps, we could find ways to merge these two disciplines. I don't believe that will happen; although, obviously, we need to do much more to find a way to resolve that contradiction by finding ways in which each discipline may be able to support the other in its own way.

This fundamental contradiction between Western European Judeo-Christian and American Indian, in my contention, is the fundamental contradiction of Indian lives and obviously can be extended far beyond medicine. In my opinion, this contradiction is really what is responsible for all of the other contradictions insofar as it attempts to utilize the philosophy and techniques of scientific humanism. This really isn't a startling idea; it's not original with me. Other people have discussed it but I would like to take a few minutes to discuss with you what I think the consequences of this contradiction are, and what we should do about it.

The single most important event in my opinion of this living contradiction and its effect on Indian people is the production of paranoia. Paranoia is an abnormal state characterized by extreme suspicion and the feeling that one is being harmed in some way. Paranoia is often accompanied by extreme feelings of hostility and hatred. There is no single characteristic which so nearly characterizes Indian people as paranoia. In my opinion this, not alcoholism, and not diabetes, is the national disease of Indian people. In fact, I think, it would be an extremely interesting investigation to study the potential that paranoia might have for leading directly to alcoholism. Other characteristics of paranoia are feelings of inferiority and more importantly an absolutely watertight irrationality against which no argument is successful. This irrationality has done more to cripple the effectiveness of Indian people in their coping with the reality of the world than any single thing that I know of.

Young John Rainer is the only person I know who is actively trying to deal with the problem of the negative self-image resulting from paranoia and the simple contradiction of Indian lives. John will ask a group of young or old Indian people, "Name ten things wrong with Indian people." Immediately, there are hands that go up all over the room and he has ten or twelve responses in an instant. Then John will say, "Name me ten things

that are great about Indian people." And then there is a pause and maybe one or two tentative hands will go up; and then, John will begin to recite what is really great about Indian people. Why is this so? It is just simply part of that fundamental contradiction that I spoke about. So what is the big deal about a contradiction? The danger, it seems to me, in all of these contradictions is that if you investigate the natural world, there are no contradictions. Contradictions get solved in nature. Water always runs downhill. When water reaches forty degrees centigrade, it always expands before freezing at zero degrees centigrade depending upon the atmospheric pressure.

It is not my fear that these contradictions we are faced with are not going to be solved; they will be solved. The question is whether or not the contradictions will be solved in a way that is beneficial for us. Indeed, if you look at Indian affairs in historical context many, if not all, of our recent activities have been attempts to resolve these contradictions. The American Indian Movement is really an attempt to resolve this contradiction. On the opposite side, in a way, the backlash is an attempt to resolve this contradiction. It is my plea that in the next days, that you have here, and in the next weeks and months, you concern yourselves about ways in which the contradiction might be resolved. I don't really have the answer to that at the present time, except that I think I can find a way around paranoia.

There was a very important paper written in the anthropological literature several years ago by Dr. Koughen, who was at the University of Arizona, now in New York somewhere. I am sure someone is familiar with that paper, in which he proposed a coping mechanism for Indian people arising from urban studies in Los Angeles and other cities in California in which, he found that the most successful Indians were those who were able to compartmentalize their lives. There were times they could be Indian and were very Indian, and there were other times when they could compete with non-Indians very successfully.

I would like to spend just a few minutes in reflecting with you upon some of the recent trends in Indian matters as they pertain to the Indian Health Service; obviously, a central concern of everyone at this conference. Again, in this consideration we can see one of the fundamental contradictions of Indian life — in my opinion the fundamental contradiction of Indian life, at least, in the field of governmental relations, that is of the reciprocal nature between sovereignty and the trust status. It is interesting to me to note that many people are demanding sovereignty recognition from Indian Health Service. This is expressed in a variety of ways. A great deal is made about memoranda of agreement; transfer of programs to tribes; negotiating as equals, and so forth. At the same time, there's actual rejoicing over the White versus Califano ruling, which reiterates the trust responsibility of Indian Health Service for Indian people. What a glorious example of a contradiction. One simply cannot be sovereign, at least, on any terms that I can understand, while at the same time, having a trustee relationship — a contradiction. I'd like to tell you some of the things and some of the experiences that I have when I think of tribal sovereignty, as a person who has spoken as long and as loud as anyone about tribal sovereignty.

The thought of tribal sovereignty comes to me when I walk along the sidewalk and walk around a young Indian person passed out. I think about sovereignty when I see a 50 per cent dropout in our schools. I think about sovereignty when I see Tribal Specific Health Plans submitted in which the tribe proper has had zero input. I think of tribal sovereignty once when I found an old Kiowa woman living in a chicken house. And I really think of tribal sovereignty when my tribe did nothing about this Kiowa woman living in a chicken house except to blame the BIA and the IHS. I think of tribal sovereignty when I find no tribe in the United States has any moral or social sanction against excess drinking of alcoholic beverages.

It would be of interest, I think, sometime to have a conference devoted to the various social, legal, moral, psychological — medical, if you will — factors relating to sovereignty. It is most interesting to me to note that the only claim to sovereignty that is really valid is that of treaties — precisely the same event that established the trust responsibility.

Quite frankly, as an old advocate of sovereignty and as a tribal committeeman, I personally at present would rather take my chance with trusteeship, than with sovereignty, as a way of solving the contradiction. Because I can assure you that even though we could lose sovereignty without losing trust status, as soon as we lose trust status, our sovereignty will be gone like a puff of dust; therefore, we must seek to preserve the two. The trust status — this is really what defines the unique nature of Indian people in legal and organizational terms.

It is this preservation that causes me to regard with some degree of concern the present attitude of many Indian people towards the Indian Health Service.

As one who has been frequent in criticism of Indian Health Service, I am concerned that in the present, unsettled state of affairs in this country, there is a real probability that Indian Health Service could be dismantled. This danger may be less following the resignation of Secretary Califano, but, in my opinion, it is still real and there are a number of forces moving in that direction. There seems to be a kind of adversary relationship that has developed between Indian people and the Indian Health Service. It seems to me to be better

suited for the field of law rather than the field of medicine. But, I admit that I am speaking as a physician. I think that most physicians would agree with me that the only valid test of any successful program is what it does for the individual patient who is in contact with an individual physician or nurse or physician's assistant. All other things are secondary. It is exciting to talk about contracts, agreements, sovereignty and so forth, but from a medical standpoint one must always come back to the question: What is good for the individual patient?

One of the other tones I have detected around Indian country is an almost jubilant response to the notice of field oversight hearings by Congress relating to Indian Health Service. We've heard some of the background of this and how Congress wants to see how the money is spent and so forth. In a way, I think Congress may be trying to get into the executive branch of government. Probably because they see some degree of action there; perhaps, to cover up the fact that Congress hasn't done a heck of a lot lately. I reiterate that Congress has not provided Indian Health Service with the dollars to do its job. I don't really object to oversight hearings, but I would like to be one of the first to point out that I do not have a great deal of confidence in the United States Congress to carry out appropriate oversight hearings. As a matter of fact, I worked for Congress for a short time on an ill-fated venture a few years ago. I was not a bit impressed with the ability of Congress to do much except to raise taxes and its own salary.

The accounting arm of Congress as everyone here knows is the General Accounting Office, GAO. These are the people who know the cost of everything and the value of nothing. I'm really not very impressed with the GAO either because I have been hearing for ten years now that they are going to throw Emery Johnson out and they haven't done that either. Let us heed Dan Press' words to see that the oversight hearings are constructive. My admonition is that each of you keep in mind the consequences to Indian people of abolition of the Indian Health Service which is a perfectly valid scientific hypothesis.

The fact of the matter is there is a great deal of irresponsibility by Indian people in the destructive criticism of the Indian Health Service to other agencies of the federal government.

Let me commend you on having a really superb meeting. It's typical of a John Belindo production — a lot of disparate pieces falling together in a comprehensive plan. I would just caution you about this conference and even tribal programs in the future that more and bigger are not necessarily better.

Ladies and Gentlemen, and distinguished personages at this conference, it is a great honor and a pleasure for me to share in this conference. Conferences serve in a number of purposes. One of the important functions — and I think we've seen it tonight — is that it's a way that we Indian people at the present time can hold communion with those who have gone before us. Gatherings like this make me reminisce about my background; where I grew up, the long, cool shadows of the Wichita mountains, and long harmonious summers in a brush arbor; or listening along a clearing of a creek to the quiet, melodious prayer spoken in Kiowa language by my great-grandfather, who as a young boy, had made the walk on foot from Palo Duro Canyon to Fort Sill. Sometimes I even reminisce about the fact that during these prayers it occurs to me that the Kiowa language is the only language I know of, and it may be true of other Indian languages, that can be spoken while an individual is weeping. I think back to the eerie terror that I have shared of hearing old Kiowa women in the middle of the night wailing for their lost loved ones. All of these things reinspire me to truly dedicate myself as Mr. de la Cruz kindly discerned to continuing the rest of my life in Indian work, a pledge which I don't think I have to ask you to share. Let us proceed to eliminate those contradictions in a way that is to our benefit of all mankind.

For me, as a physician, my charge to you in the days, weeks, and years ahead is to keep foremost in your mind the question: What is it about my position that is of benefit to the individual patient? Medicine is a glorious way to approach all of life. I have found the admonition of one of my professors to be very worth remembering and I believe it applies to nonphysicians as well. He said: "It is a duty of a physician to heal sometimes, to treat often, and to comfort always." I have spoken, I hope.

JOSEPH DE LA CRUZ: Before I make my final announcements, I would like to say that Dr. Rhoades gave a very inspiring speech.

The final announcement is that last night we had the Pow-Wow, and tonight the National Indian Health Board is sponsoring and hosting a dance over at the Sheraton Ballroom.

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Wednesday, July 25, 1979

Third General Assembly

DONALD LAPOINTE: At this time I'd like to reconvene for the Third General Assembly of the Third National Indian/Alaska Native Health Conference. Lionel Boyer, Vice-Chairman of the Shoshone-Bannock Tribe, a member of the Northwest Portland Area Indian Health Board, will give the invocation.

LIONEL BOYER: (Whereupon, the invocation was given in his native language.)

DONALD LAPOINTE: On behalf of the National Indian Health Board and the planning committee for this conference, I'd like to welcome you to the Third General Assembly.

I'd like to express particular thanks to the planning committee on the way that the days of this conference were set up. The first day dealing with legislation affecting the native people and their health programs. The second day community services and, I believe, we held the best for today.

Today will be a whole day session on mental health. It affects each one of us, each one of our families. We have with us Dr. H. C. Townsley, Director of the Indian Health Service Mental Health Program, out of Albuquerque, who will be giving a review of the mental health programs for native people through Indian Health Service. Those programs are limited and they're limited because there's not money available to carry them out as they should be. It's up to each one of us to make it known through people serving our districts and Congress. Let them know that there is this need and it's only through your effort that we will be able to get the funding so necessary to carry out the programs that are enabling our people to enjoy the best health possible.

I have worked in the area of mental health since the early 1960's, but, it started for me when I was nine years old. At that time I made a commitment that I would do my best to see to it that other people would get the proper treatment and care.

I wasn't affected by mental health problems at nine years old personally, but it affected our family and at that time they were using terms that were not too favorable, terms to a nine-year-old that were just words, not knowing what was really going on. I'm thankful that since that time giant strides have been made in the treatment of mental health problems.

Since the 1950's the advances have been great, since like 1956, when they started using the drug therapy treatment, the mental hospitals in our country have virtually emptied out. I worked in a state mental hospital for eight years. When I first went to work there there were 3,400 patients and they felt that the hospital at that time was 25 years behind the times in treatment yet it was one of the leading hospitals in the country.

There were a lot of renovations that took place after that in the early 1960's. They started using behavior modification in treatment of patients who had been in the hospital for a long time, patients who they felt would never leave, long-term schizophrenics and the like. They were successful in getting a number of those patients back into the community.

I left there in 1968 and went back to the university where I worked with all different types of mental and physical disabilities, including the blind, and was one of 10 people in the midwest chosen to take part in a special training program in rehabilitation serving affiliations in several different areas, including the Metropolitan Society for the Blind, the Ford Motor Company Medical Records Section and Tri-County Area on establishing a central job bank for the handicapped. I worked with the handicapped and worked with the Jewish Vocational Services as well as the Detroit League for the Handicapped, Goodwill Industries, in training other people to work with the handicapped and mentally impaired.

It was a really rewarding experience. I had opportunities to serve three different internships.

It was ironic that the year I graduated from high school I left the reservation and went to the city, 20 years later to the day I finished that program at the university and went back to the reservation. At any rate, I've been involved in education and health and trying to promote health careers for Indian students and the like and getting Indian students into allied health professions and trained to help wherever possible because there's such a need.

We are fortunate on our reservations to have comprehensive health services. We are one of the first in our area to get that type and they use our health program as more or less a model for those reservations getting contract health care.

The nearest Indian Health Service Hospital is some 400 miles away so it makes it kind of hard for our people to get there. We have to utilize the public hospitals, the county hospitals, the general hospitals in the vicinity, and sometimes our people have to travel up to 75 miles to get the treatment they need because of the small local hospitals, and the services that we are able to obtain from them are not always compatible with our health needs. They don't always receive us with open arms. We sometimes have to send our people 30 miles away for emergency treatment because the local hospital will only allow Indian Health Service physicians to admit a certain number of patients per year. Anyway, we are working on the problem.

Our clinic is directed toward preventive-type medicine and we are trying to develop the type of programs that will adequately serve our reservation area. Several other clinics in the area

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GEORGE EFFMAN, CHAIRMAN of the National Indian Council on Aging, addresses Third General Assembly on recommendations developed by the workshop on Indian Elderly.

have been patterned after the one we've had operating since about 1973.

We were fortunate in Michigan recently to obtain the former Kincheloe Air Base as our first Indian facility. It's been operational since about the first of the year and provides outpatient treatment plus dental care services. We are at last going to find out how many Indians there are in Michigan and what the need is. The facility at Kincheloe is just fantastic and hopefully we'll be able to get into health manpower training. We are utilizing just a small portion of the facility and we have options to open up other areas there, I believe, for Indian Health Service, including a job corps center.

In Wisconsin they are also developing health programs. The health facility there, as well as at the other reservations in the area, are trying like all the rest of us to make the best of the contract health care they're getting. In Minnesota at Red Lake they are getting a new hospital so we are making some progress even though the funding is not adequate to meet the total need.

I'm sure the rest of you in the other Indian Health Service areas face similar problems and know what these are.

I would like, at this time, to introduce James Smith, the Director of the Billings Area Indian Health Service, who will give highlights of yesterday's human services workshops.

JAMES SMITH: Good morning, again, ladies and gentlemen.

Our plan this morning will be to ask each of the people reporting to give a brief overview of what happened in the workshops. Having gone around yesterday and sort of visited each of them briefly, I tend to think that maybe it would have been well to repeat the workshops three or four times in looking at the number of people in attendance. I think the participation, the attendance, was just fantastic, in fact, most of you could hardly find a place to sit. Without further ado I'd like to call on George Effman, who was a facilitator for the Indian elderly workshop.

GEORGE EFFMAN: On behalf of the National Indian Council on Aging and as chairman of the board, I would like to thank the National Indian Health Board's chairman and members for the opportunity to share with you the concerns that we have for the American Indian elderly.

I'd also like to thank the executive director and staff for inviting us and sharing their workshops. I was really happy yesterday to be able to see the interest and as Mr. Smith already pointed out, both of our workshops were really filled to capacity and I thought we had plenty of handouts. I figured at least 50 for the morning and 50 for the afternoon and I didn't have sufficient amounts for either so I apologize and those that want to get some more material sign up so we can send some out to you.

I'd also like to state that it's really great to be in the Northwest. I lived up in this area for 11 years.

As I said, I was really pleased yesterday to see the attendance and the interest that we have in our workshop. I learned a lot from you that participated, from what you are doing on your reservations, your extended care facilities, your nutritional programs. I would like to share with you that I have been to Washington, D.C. and we were working on a lot of good things back there like our titles and so forth.

One of the things that I think has been long neglected, not only have our Indian elderly been kind of neglected, but, also our young people, it's just the middle people who have more or less been taken care of. So I'd like to emphasize that our programs should be geared to the young and to the elderly.

I'm really happy that we were able to work with the Office of Aging to try to change some of the Older Americans Act through amendments. We came up with Title VI. We discussed this in our workshop and I paralleled, the Older Americans Act, we had nine titles, if you recall, in '78, then in October of 1978 they made some amendments. We

find that they had also included Title VI, Direct Grants for Indian Tribes.

One of the purposes of this title is to promote the delivery of social services, including nutritional services, for Indians, that are comparable to those under Title III. We discussed this at length and one of the disappointing things that we have been combating is the fact that even though the President did sign this title he did not appropriate any money for implementation and then about three weeks ago, we were really devastated by the fact that the House Appropriations Committee voted 10 to 9 against giving us any appropriations. Last Friday we had another meeting with the Senate side and at that time they decided to pass the appropriations for the Older Americans Act. I called the office yesterday and got word that the amount was, at that time, $8 million. This morning a gentleman who talked to a senator said it was to be $12 million. I hope it is twelve.

The thing I would like to stress to all tribal groups here is to send telegrams and to call and write letters to your congressmen and senators to give us more money. We did a brief survey and we need approximately $30 million to implement a program that would be applicable and would be utilized by the elderly throughout the nation.

I appreciate the opportunity to make this brief report.

JAMES SMITH: Next, I'd like to call on Albert Pooley to give us a report on the substance abuse sessions.

ALBERT POOLEY: We had a very good workshop yesterday. We had a very good group in both the morning and the afternoon sessions. In constructing this workshop we debated in terms of what would be most appropriate to cover in the limited time available.

We had two objectives, primarily, to give the group some sense of the problem as there has been a lot of speculation about the extent of the problem, everywhere from everyone using drugs to there being no problem. The research information in this area has been very limited so we did cover some of the things in the areas of magnitude of the problem.

The other section of the workshop more or less focused around what resources are available to Indian populations if they would like to get involved or seek support in the areas of substance abuse funding.

One of the things that we did come up with in terms of how the thing was structured was that in order to actually begin to provide services to our Indian people on reservations it is necessary to first have the support or the endorsement of our tribal governments. So we first of all identified the tribes and our Indian people as being the primary resource to begin to work with.

Secondary to that was to begin to look at other national and local organizations committed to working in the areas of substance abuse, such as the National Indian Health Board, the National Indian Board on Alcohol and Drug Abuse, the National Indian Council on Aging, different groups like these, because we feel that when you want to get things changed at a national, regional, or local level the endorsement or support of these groups always helps.

Thirdly, we looked at various national funding sources, such as the National Institute on Drug Abuse, in which the prime purpose is to reduce or prevent drug abuse among the United States population which includes, of course, the American Indian. Up until this time they have been very lax in their appropriations for American Indians in the field of substance abuse. We need to put them on call to have them realize that we do have a concern and a problem. We do want to prevent the problem from getting any bigger so we've got to hold them accountable for giving us support.

It was also mentioned from the floor that the Indian Health Service likewise has a direct responsibility in this area and should begin to view it as something deserving resources in manpower, training, whatever. Other agencies work closely with American Indians, such as the BIA, should have some direct responsibility in helping to prevent or reduce the drug problems among our young people. Just in closing, if any of you want more information there are a number of people throughout the country that I think would be very helpful to you. Feel free to contact me or my office and I'd be more than happy to help you.

JAMES SMITH: I'd just like to second what Al was saying. I think many of us are not really aware of the increasing problems that we've got in substance abuse. We spend an enormous amount of time concerned about alcohol abuse and yet we find, on many reservations, I think, in particular, those where we seem to think that we don't have a problem, many times we end up having more of a substance abuse problem than at those places where we normally would expect it to happen. I would just suggest that you take advantage of the offer that Al has made and also if you have an interest when you get back to your own reservation of talking with some of the educators, talking with some of the students, and find out if a problem does, in fact, exist and, if so, how severe it is. Let's see if we can do something.

Following up on substance abuse I'd now like to hear from Pat Mayo on the alcohol abuse workshop.

PAT MAYO: Many of you know I'm not a Native American. Everything that I know about Indian alcoholism has been shared with me and taught to me by the people who really do the work, the individuals in the field. They have been very gracious in sharing their knowledge and information with me which allows me, who has a reputation of being glib of tongue, to take that and put it down on paper in their behalf.

I have a great debt to the Papago people and to the people of the Pacific Northwest who have spent a long time and great patience in trying to teach me what the problems are so that I, in turn, can serve to try and educate my colleagues and the non-Indians who still harbor massive ignorance about the extent of the problem and the fact that much can be done to resolve it.

I'd like to thank Virgil Gunn from the Colville Nation who provided excellent services as a moderator for our panels in the morning and in the afternoon, Bud Mason from the Indian Health Service Office of Alcoholism who was the facilitator, and, Dr. Ralph Dru from the Albuquerque Office of Alcoholism who stood in for Dr. Andre.

A good part of the workshop was spent reviewing the current impact of alcohol in Indian communities. I don't need to burden you with that, you know far more the devastation that alcoholism causes in your communities than any set of statistics could possibly relate. Everyone suspects that the statistical information under-reports the true magnitude of the problem, however, as you are aware, the Congress of the United States requires numbers in order to produce dollars back. So it's important for us to provide a sound data base which describes the problem.

Bud Mason was able to provide a very nice summary of the history of Indian alcohol programs and I think it is particularly important to note that in his summary perhaps the most unique and special thing about Indian alcohol programs is that the movement to resolve alcohol programs in the Indian communities came not from professional people but from recovered Indian alcoholics themselves. They got together, looked at one another, and said, "We're sober, we did this, we can share this." They began to press on the professionals and said, "Help us. Help us do what we know can be done." Finally they got federal funding from the Office of Economic Opportunity and then the National Institute of Alcoholism and Alcohol Abuse, and, now the Indian Health Service is responsible for following in what is, I think, an outstanding example of grass roots and community motivation. The Indian Health Service has a lot to live up to.

After reviewing the problem, which was very expertly described by Bud Mason and Ralph Dru, participants from the morning and the afternoon sessions met and tried to identify those issues which we felt were most important and most pressing out of the enormous wealth of information that had been presented. There are six items that surfaced and I believe there was a consensus of the group that these are the issues that really need attention and the support of the agencies involved and of the National Indian Health Board.

The first and most obvious is that when Congress mandates an agency to do a job then they need to provide the money to see that that job is done.

Secondly, Indian communities should be given all possible assistance by the agencies in those communities to develop their own human services research programs which meet the needs of their particular communities and not a model that is developed in the Southwest to be imposed on the Northeast or the Northwest to be imposed on the Southeast.

Preventive programs must be developed and supported if we are to break the cycle of the destructive patterns of alcohol abuse in the Indian community and prevention is a difficult thing to quantify and for which to demonstrate cost effectiveness. A dollar spent on prevention today may not show itself as well spent for upwards to 10 years. The children must be turned around and helped to have better self-esteem, a better sense of direction, pride in self and a knowledge that they do not have to drink like their fathers drank.

It is particularly important in the area of prevention that the Bureau of Indian Affairs, which still operates schools for Indian children, be involved in a meaningful and committed way to doing what it can within the school system. The Indian Health Service has continued to provide appropriate medical services and the NIAAA is still providing funding for new programs. So there are numerous resources that need to be welded together to address this problem.

It is very important that the Indian Health Service professionals be trained to understand the disease of alcoholism as well as to understand how it affects Indian people. Our professionals often lack that knowledge, although we assume that they have the answers to everything. Indian Health Service has also been charged with the responsibility for training para-professionals. The people in the communities who do the work are hungry for information and assistance. It's a major responsibility to improve upon and design training for these people and it's a very important goal which must be shared by the Indian Health Service and the Indian Community alike.

It is especially important to recognize that there is no single treatment for alcohol abuse but a wide range of modalities which can be brought to bear. Particularly important in some Indian communities is the emphasis on the positive attributes of the culture which might help an individual to become and remain sober or to change the pattern of drinking to a less destructive one. We must keep open minds about all of the alternatives for treatment presented to us and the Indian Health Service professional people must be helped to understand that perhaps a traditional approach would be the most appropriate and that it needs to be supported.

Finally, there needs to be attention to programs addressing the needs of Indian and native people in our prison systems. It was brought to the attention of the workshop that the

majority of incarcerated Indians are there, not so much because of the crime on the records but because they were drunk when they committed that crime and were caught. There is very little organized outrage. I know that Harold Belmont is here at this meeting and is trying to reach several people to put together a national task force to address this very important issue in a much neglected area of concentration.

Those are the six items we identified as particularly important and worthy of serious attention. Certainly, alcohol, while a major health problem, is being given a good run for its money by substance abuse, but the methods which address a variety of problems in the Indian community are really essentially preventive ones that start with our children and it's very important that we begin to look at what we can do from birth through grade school to arm people to make appropriate decisions and feel good about themselves so that they need neither drugs or alcohol to lead a productive life.

JAMES SMITH: I'd like to now call on John Emelio, Director of IHS Emergency Medical Services, for a presentation of the Emergency Medical Services Workshop.

JOHN EMELIO: Emergency Medical Services is a relatively new enterprise in the American health care delivery system. It was officially born in 1973 with enactment of Public Law 93-154, the Emergency Medical Services Systems Act of 1973. It has moved swiftly and dramatically across the country since passage of that act and it's probably the only program that I know of in which the Indian health care delivery system hasn't had to play catch-up, we haven't had to justify our resources based on lagging behind the rest of the nation.

We got into this program right from the beginning through a strong commitment of tribal government and assistance from Indian Health Service and I would say today that we are right up with our counterparts in rural America and in many, many cases ahead of them. It's been a dramatically moving program within IHS and this has been done, as you know, without direct appropriations to us. The only appropriation for EMS is in Alaska, specific to Alaska, and it's been done through a combination of resources, a tremendous amount of commitment, work and effort, principally on the part of tribal governments.

The two workshops yesterday had good participation and involvement. There were approximately 100 people in the first one and about 60 in the afternoon session. The format was pretty much a presentation by four or five people with discussion in between. Three resolutions were passed in two sessions and incorporated into a single resolution at the conclusion.

Among the presentations, we discussed the background of the program, the legislative authority, Indian Health Service's current program, its policy, structure, delivery system, resources both within IHS and elsewhere, the accomplishments to date and the emphasis planned for 1980. I think this was of interest because we, in planning the 1980 program, don't always have the benefit of this kind of input and feedback.

What we have essentially identified as a program emphasis — well, up to now it's been a matter of formally designing the program, getting a structure to function and pursuing the one missing component in the EMS system which was ambulance service. I think seven or eight years ago you had to look pretty hard to find ambulance service in Indian communities and today, most communities have it. With that component essentially in place what we are looking at in 1980 is development of a first responder program which would allow us to respond to at least 90 per cent of all emergencies within 15 to 20 minutes with a medically-trained first responder, or allied service responder who has two-way radio communications and medical treatment to treat and stabilize the patient until the patient is in the hands of a higher level of sophisticated care. I think that we will in 1980 get this program under way and if it's successful we'll see it in most places in a matter of a few years.

A second initiative in the upgrading of the Indian Health Service Emergency Department is to improve emergency medical facilities, and we have identified a source of funds to do this. In many, many locations, we have what we call emergency rooms that are not properly equipped, not properly staffed and the people are not properly trained. We need to raise this level of emergency medical care.

The EMS program as a whole in its definition deals with the patient from the point of incident right through rehabilitative care or patient outcome and it's a matter of building each link and coordinating them.

A third category that we hope to work on is a large-scale commitment to training. We need training at the citizen level. We're working on an audiovisual tape that can be put in waiting rooms and used in school systems as part of health education programs to give citizens training on how to control bleeding, open and maintain airways, various first level life-support measures and how to use the Emergency Medical Services network so that at least life can be sustained. From citizen training to first responder training, emergency room nurses and physicians, we have many initiatives under way so that next year, I hope, you will find that these training opportunities are accessible. In the past they've been very hard to identify.

The Black Hills Indian Health Service Training Center in South Dakota and the Tahlihina Training Center in Oklahoma have committed 14 weeks to EMS training next year. We are still pursuing resources to obtain the instructors and the

necessary training equipment but I think we'll find that. The Indian Development District of Arizona, which is a consortium of Arizona tribal governments, has applied for an emergency training grant. We've gotten essentially a verbal commitment from the Department of Labor to fund a private sector initiative program to establish an EMS training academy at the Sunrise Ski Resort of the Whitemountain Apache Tribe at Whiteriver, Arizona. If they get that grant they'll be able to offer emergency medical training at a very low tuition cost.

Dr. Tom Bonifield, who is head of the IHS EMS Research and Evaluation Program, presented projects that he is working on. One of them is a research study in Alaska at the Bethel Service Unit of emergency care and delivery in the bush areas. This is really an interesting project and if the results prove what we think it may completely revise the IHS delivery system in the bush areas of Alaska. He's evaluating the first responder program from both a medical and cost effectiveness standpoint. Dr. Bonifield was also one of the primary authors of the Resource Allocation Criteria that were designed for EMS that we're basing resource distribution on. If there are evaluation projects in this field that you may be interested in, Dr. Bonifield is stationed at the Puget Sound Indian Health Service Unit in Seattle.

Rex Franklin, who is head of the Highway Safety Program for the Bureau of Indian Affairs, described his program. One of the components that is funded under that program is EMS. We are working on a memorandum of agreement between BIA and IHS that would make these funds available to us. We would then award grants to tribes and process the EMS component through IHS. This memorandum of agreement has now been completed to our satisfaction and is being sent up the organizational chain for review and signature. Hopefully by next fiscal year we will be working with that part of the Highway Safety Act.

Dr. Stanley Glen, who is the EMS coordinator for the Albuquerque area, made a presentation on how things are in that area and similar parallels that can be drawn from other areas. David Means, who established the Emergency Service for the Northern Cheyenne Tribe in Montana, described how he did that and the success of the program. There's been a lot of interest and discussion with Dave. When he got into that program he had applied for a job with Indian Health Service and was approached one day and told, "Well, if you want a job you have one. You can be an ambulance driver." This was a Friday. He was told, "You can start this weekend, you can carry the operation for the weekend. Here's the keys. There's the station wagon." He talked about his Saturday night fever because he encountered all kinds of really serious medical crises without any training or equipment. This is what it was like, not that many years ago. It was nice to be able to hear that in terms of the history rather than in terms of the current program.

The workshop discussions were pretty much centered around technical issues of the program and the problems with funding because funding is essentially temporary and nonrecurring. It's where efforts have been squeezed out, and a lot of it is one-shot type of funding. There is not a lot of security in this program because there is not a basic appropriation and current commitment of funds, so we live it with a little bit of concern. I believe that the program has much community support, and as long as it does, I think one way or another it's going to survive. To the extent that the program does not become efficient and does not service the people then it will probably fade away. I don't see that happening in the foreseeable future.

The workshops discussed the need for training and for Indian Health Service to have full-time EMS consultants at an area level. I might mention as far as appropriations, before I forget, that last year the Senate Appropriations Committee passed an add-on to the Indian health budget of $1.5 million for this program but it was dropped by the conference committee of the House and Senate. This year John Belindo testified on behalf of NIHB in joint testimony with NCAI, NTCA and the American Indian Health Care Association. One significant part of their testimony was to ask for $10 million in support of the Emergency Medical Services Program. This year the House Appropriations Committee reported out a million dollar add-on for EMS. To my knowledge the Senate has not reported out yet but we could well have for the first time a national base budget for EMS.

The workshop resolution called for NIHB and IHS to support the appropriation or pursue an appropriation for EMS and/or redirect resources from other activities, if possible, to support this program on a recurring basis with a special emphasis placed on widespread training of tribal EMS assistance personnel and consultant services, and a full-time commitment of consultant services on an area-wide basis.

I really appreciate and thank NIHB for having us on their agenda and for the activity that I was able to participate in. Indian Health Service does have a packet of EMS information that we send our upon request. If you are not able to obtain this locally I would suggest that you write to me and I'll mail it to you.

LUANA REYES: The urban Indian health care workshop attracted about 55 people in both the morning and the afternoon sessions and it was an interesting mix of old faces and some new ones as well. I think it was a fairly good workshop but it was a little difficult getting people started, making comments and recommendations on the subject matter on the agenda. Once they got started it was a little more active in the afternoon.

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I had two facilitators to help me, Dr. Lionel deMontigny, Director of Community Development in Indian Health Service and Don Donaldson, Chief of Community Development, Indian Health Service, Phoenix was also there, and, the Area Director from Alaska, Gerry Ivey, who was the moderator.

The urban Indian health care workshops were presented to review and discuss pertinent national level issues that affect urban Indians both directly and indirectly. Urban and tribal input is both necessary and desirable in the attainment and full realization of a comprehensive health program that offers quality services in sufficient quantity and rendered in a culturally acceptable manner to American Indians and Alaska Natives. With this objective in mind, many of the P.L. 95-626 Urban Project Report recommendations were discussed with a group consensus that the following recommendations be brought to the attention and consideration of the Third National Indian/Alaska Native Health Conference attendees for further analysis and action.

Many of you may or may not know what urban Indian health care programs are required to seek funds from other sources so a considerable amount of discussion was held during those workshops on alternate funding sources other than Indian Health Service. The 626 Report addresses some of those issues.

The following recommendations came out of that report:

1. That Congress appropriate the full funding authorized under P.L. 94-437, Title V, to enable the establishment, continued operations and/or expansion of urban Indian health programs.
2. That urban Indian health programs be given priority consideration for funding under Section 330 of the Public Health Service Act and Urban Health Initiative, for the establishment, continued operation and/or expansion of urban Indian health programs. Further, that the geographic and target populations criteria be revised for urban Indian populations. The interpretation of a service area as a specific city or county in the 10,000 target population requirement has made access to Urban Health Initiative funds difficult, if not impossible, for many urban Indian programs. By either lowering the target population criteria and/or expanding the geographic service area criteria, urban Indian programs would have easier access to these funds.
3. That IHS contract health services regulations be revised to include eligibility for contract care services to all Indians regardless of place of residence and that funding be increased to enable services for all urban Indians.
4. That urban Indian populations receive priority consideration for National Health Service Corps assignees.
5. That existing service providers (including local health departments and Bureau of Community Health Services and NHSC service sites) establish satellite outpatient clinics in areas with significant concentrations of urban Indians and that policy boards comprised of urban Indians be formed to provide input on services.
6. That direct funding through Title V (Maternal and Child Health) and Title X (Family Planning) of the PHS Act be made available to

80

urban Indian health programs. The current method of allocating funds through states to local agencies often results in statewide operated programs and/or funding to existing agencies which are often not accessible to urban Indian populations.

7. That funding be made available for Indian-operated advocacy, outreach, transportation and other supportive services to facilitate access to existing services for urban Indians. Further, that existing service agencies be required to employ Indian people to provide these services where direct Indian-operated services are not available.
8. That funding under P.L. 94-437, Section 102, be increased to facilitate the development of Indian health and allied-health professionals and that funding be allocated on a more equitable basis, that is, priority consideration for tribal/union programs and better geographic distribution. Further, that urban Indian programs receive priority consideration for funding under Section 787 of the PHS Act, Health Career Opportunity Programs. Additionally, that existing health care agencies be encouraged to serve as preceptors for the placement of Indian health professionals recruited under these programs.

Discussion also focused on suggested amendments to the Indian Health Care Improvement Act. Consensus of the workshop was that one, the authorization for Title V be extended through 1984 (it currently expires in 1980); two, that a specific title be added to address the concerns of rural Indian health problems; three, that the population issue, that is, the requirement to use the 1970 Census figures, be addressed so that the Urban Specific Health Plans, a four-year plan based on an undercounted population, can be updated when more accurate information is available from the 1980 Census.

Considerable discussion was held concerning the IHS requirement in the regulations that the board members for urban Indian organizations be all Indians. Examples were cited where some funding agencies would not give funds to groups which were not representative of the community at large, that is, board membership must be open to all clients and could not be restricted to Indian membership only. The group recommended that this issue be studied and perhaps amend the regulations in such a manner that the Indian group decides what constitutes Indian ownership or control and whether or not they want non-Indian representation on their boards. The issue of composition of boards of directors for urban health programs was discussed but no consensus was reached. It is an issue that needs further attention.

I think that we had two very productive workshop periods in which we talked about some issues that have been bothering urban Indian program people for a long time. The interchange, was, I think, effective, the participation was spontaneous and I'd like to thank some 100 people who participated. I think that we have some concrete recommendations to make that will improve the health of Indians no matter where they live.

JAMES SMITH: I'd now like to call on Dr. Robert Birch, IHS 437 Project Manager, to give us a rundown on the workshop dealing with Amendments and Recommended Changes to 437, a workshop which, I think, was very highly attended.

DR. ROBERT BIRCH: I'll make my report rather short because this is a continuing activity. It certainly is not going to be concluded here, it's going to go on in terms of recommendations. I appreciate what Luana just reported from the urban workshop because those are some clear recommendations that affect 437. Also, the workshop on Monday on Tribal Specific Health Plans and on Public Law 95-626, produced 11 recommendations.

In our workshop sessions yesterday we read those recommendations from the Monday workshop and tried to tie all these things together. As Jim pointed out it was very well attended, Meeting Rooms E and F were packed for both workshop sessions, which was super. Like Luana just said, there were some old faces and some new faces and I mentioned that at the meeting too and then I got to wondering if I offended anyone. I think the point is that there were some folks there that had been at our first orientation session in Salt Lake City at NCAI in October of '76, just a couple of weeks after the Indian Health Care Improvement Act was signed. Those same folks had been involved in these meetings and activities and planning and operational efforts in 437 ever since. Of course, those same folks were involved in what led up to 437 and have been involved in Indian health matters for years and years. So we've got a reliable group of core people that have been with this effort for many years. The nice thing, in addition to that, is that there is also a whole group of new faces, folks that I find now are health planners or active in health planning departments of various tribal or urban enterprises. That's really super because we've come so far on what's happening, the many good things that have happened with 437. As John Emelio pointed out, the remarkable improvements that have occurred in the last few years have been kind of a theme that's been coming through at this conference.

Our workshop had a brief period at the beginning of each session giving some background and in many ways I felt that was unneccessary because most everyone in the room was very well familiar with what is happening with 437. Most of the people there were familiar with

and had a good background with 437 activities. We handed out a progress report which caused many people to sigh with relief when they found it was one piece of paper on both sides of the page and it represented very briefly some of the real accomplishments over the last two years in 437. I guess that's got to be an accomplishment in itself, most of our reports are 10 or 12 pages with a whole bunch of attachments. It takes the major part of the day to read the things. So we're learning some tricks ourselves.

We're going to try to keep our correspondence brief and very much to the point so people that are busy can at least read it and understand what's going on. That was the best example we could give. We passed out that progress report and I think that helped folks in making their recommendations. Incidentally, I brought 800 copies of that, handed it out at the workshop to probably 200 people, put the rest out on the tables, and after the workshop I went out there and they were all gone. So people are interested in the materials and I appreciate that.

Also, as part of our continuing 437 communications effort, we have a mechanism where we send materials out directly from our office to the national Indian organizations and to our area 437 coordinators. So, for example, a coordinator in the Billings area, Jim's area, is responsible then for seeing that those materials get out to all the tribal and urban leaders, the state universities, the schools, the state health departments, anyone else that is interested in 437 activities. Larry Thomas has been doing a super job of that in the Billings area. This has been true throughout our 12 Indian Health Service areas and programs.

I encourage you folks through your tribes or urban groups to communicate with those 437 coordinators. Those people are the key communicators in this whole mechanism and this has been so for the last 2½ years and will continue to be that way. Through that mechanism we have set up a method for people to communicate back and forth through the areas, through headquarters, so that we're not missing areas, so that we're not going directly to headquarters and leaving key people out of this. It's a communication mechanism that does work. We discussed that some at the meeting yesterday.

Through that communication mechanism in April we distributed an invitation for everyone that was interested to submit recommendations for possible changes or additions to improve 437. There was a due date on that in the middle of June and we received recommendations from five Indian tribes, from seven tribal organizations and from five individuals. Those recommendations totaled up to 44 individual recommendations. They were summarized and organized by sequence in the act and those have now been recirculated. So when you folks go home hopefully your tribe or urban group will have a copy of that dated July 18th, which is the second call for these kinds of recommendations.

We also handed that out at the workshop. Again, there were 800 copies of that and, again, I see this morning those are all gone. With that was a cover memo that explained what the recommendations were for, set up deadlines for submitting these recommendations, said a little bit about what they were going to be used for and then also summarized the 44 recommendations we've had so far, and, last, a worksheet, which we have asked for people to fill out when they send in their recommendations.

The next date for additional recommendations is August 15th and that means you send those to your area coordinator and he or she will forward them to headquarters and from there over to my office. They have to be there by August 15th because we want to organize all the recommendations and then review them with our national Indian organizational consultants who will be meeting with us in August. So there's that follow-up and that's why I say that the recommendations are not complete here.

We got excellent recommendations yesterday and a large number of them. When you pick those up over on the tables today take them back to your tribes and go back through the mechanism that was pointed out, back to the service unit and the area health boards, and then for eventual consideration by the quarterly meeting of the National Indian Health Board. We've got a schedule set up that the results of the national meeting in August will get to us in time to be considered for inclusion. The inclusion that this is all working up to, of course, is the National Plan which will constitute the Secretary of HEW's recommendations for Fiscal Years 81-84 for carrying out the provisions of the Indian Health Care Improvement Act.

So yesterday in the workshops we tried to draw the relationship between everything we've done so far and how this all relates right down to the National Plan that is the consolidation of all the Tribal and Urban Specific Health Plans and how that National Plan will have a section on recommendations. The recommendations would come from all these recommendations that came out of the workshops, that are coming from the circulation of these comments around the country, and those recommendations then will be policy recommendations, legislative recommendations, and authorizational recommendations.

There was some concern yesterday on how these would be handled because right now we've got 44 from our first circulation nationwide and 11 from the Monday workshop and I'm not sure what the total was yesterday, but I'd say probably another 20 or 30, and other numbers that have come in by August 15th. So we may have up to a

hundred recommendations and how we'll handle that is that we'll organize those by sections of the act and then try to combine them because I'm sure there will be many dealing with the same subject. If there are any that are opposed to each other or anything else that we have to work out, plus the entire list itself, we will review that with our national Indian organization consultants in August. That group then will make recommendations on how these recommendations will be included and, again, as we have with the Tribal and Urban Specific Health Plans, all the concerns represented in those recommendations will be included in the National Plan.

So it's a super process and I think since the Indian Health Care Improvement Act was signed in September of '76 there have been comments from all different areas of the country in and out of the Indian health program of people that have acknowledged and have been amazed at the massive participation that has gone on in all aspects of 437 planning, regulations development, operations, evaluations. This obviously is an Indian program and the Indian people are vitally involved in every aspect. As I said before, that's the fun that I've had in being a part of it.

I appreciate the participation we had at the workshop and everyone's willingness to jump on to those tables and get copies and I certainly urge you to take those home and consider anything — 437 is a great law but it's not perfect and if there are things in there that you can recommend that would improve it to serve Indian people, please make those recommendations. Get them in to our offices in Rockville by August 15th. Those that arrive by September 15th we will try to include in the final draft plan. Those that come after September 15th will be included in other documents, for example, each year we have an opportunity to submit a legislative initiative package which is something that goes through the layers of the department that identifies where amendments need to be made to existing public laws or where new legislation is necessary. So, really, what we are doing here is setting up a method that Indian people and others that are interested can submit recommendations regarding 437 now and indefinitely.

JAMES SMITH: Our final report today will be from NIHB Deputy Director John Powless on what took place in the Title XX and Indian child welfare workshop.

JOHN POWLESS: To give you a quick update on Title XX and the Indian Child Welfare Act, those two workshops were combined and were very well attended. The first subject that was discussed was Title XX of the Social Security Act and the amendments that are being pushed for so that tribes can receive funds directly from the federal government to run human services programs such as mental health, drug abuse, and numerous others.

Presently the federal funding is sent through the state government rather than through the tribes and tribes are being asked in a lot of instances to water down their sovereignty. What's being pushed in a lot of these cases is to have tribes ultimately, in my opinion, become political subdivisions of the state. If they have the tribes going through the states to get funds from the federal government it's just a matter of time before the states become the trustee or, at least, the states are going to be the ones responsible for implementing treaty rights. The treaties are not made with the states, they are made with the federal government.

We're coming, I think, to some very crucial times when either a tribe is going to be forced to go in there and get its share of the federal funds because they do count Indian people along with the other state citizens in receiving allocations. The question is whether or not the tribes want to be counted along with the states and be accountable to the state government.

We will have the amendments discussed copied for you to take back and to start to push for passage. People such as John Lewis and Goldie Denny-Todd have been working on this. If you need information on how to get in contact with these people or if you want more information on Title XX do not hesitate to get in touch with the Staff at the National Indian Health Board so that we can begin to develop a grass roots movement to push these amendments through so that we can continue to maintain our political integrity because it's going fast unless we take some very tough stands.

On the Indian Child Welfare Act we discussed the atrocious regulations that have been developed by the Bureau of Indian Affairs, the numerous requirements that are being placed on tribes in P.L. 280 states in order to reassume jurisdiction. These require tribes to petition the Secretary of Interior for approval to get jurisdiction back from the states, and you have to include numerous things in those petitions before the Secretary will approve, I repeat, approve your petition. The Secretary is going to be deciding whether the Indian people are competent and capable of protecting their children. That's what it's boiling down to.

In those petitions you have to include things like the number of children on your reservation; you have to predict the number of child custody cases that you'll be having on your reservation; you have to cite the authorities in your tribal constitution and bylaws by which the government assumes authority over child custody proceedings. If you don't have that within your tribal constitution, especially if you have a constitution that's been set up under the Indian Reorganization Act of 1934, there's going to be a long process that a tribe is going to have to go through in order to amend its constitution which requires the Secretary's approval.

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NIHB DEPUTY DIRECTOR John Powless (right) takes a moment to chat with conference attendee following completion of third general assembly.

Another provision is that you have to identify the territory over which you are going to be assuming jurisdiction. You have to identify your tribal court system, how that's going to be set up, whether it's capable. You also have to identify the child services that you are going to be providing and those services have to be sufficient to meet the needs. If tribes do not already have those services and courts or administrative bodies established then your petition is going to be forestalled until you can develop those things.

The other part, there's a number of things wrong with the law itself, such as the fact that all the children in Alaska born after 1971 are not considered Indians for the purposes of this law because it requires that, at least in Alaska, the children be members of the corporations. So if you were born after 1971 in Alaska, which was the closing date for obtaining membership, you are not considered an Indian person for purposes of the Indian Child Welfare Act.

There's also a whole section in the regulations dealing with recommended guidelines for state courts.

These contain a number of loopholes, clauses such as in transferring cases that if a judge can determine that there's good cause that the case shouldn't be transferred to a tribal court then the judge doesn't have to transfer it. A good cause is whatever the judge can come up with and justify.

In emergency removal situations in Public Law 280 states social service people and courts could go right out to the reservation and take children that they felt were in danger of physical harm without working with the tribal government or the tribal courts. In those kind of instances and where there are numerous child custody problems I see tremendous conflicts arising, especially if the tribe is developing its own police system. These regulations are creating more conflict rather than trying to solve the problems being addressed by the Indian Child Welfare Act.

Another problem with the regulations is that Indian people do not really become involved in a case until after it's been in the state courts. There's no involvement prior to the court cases and that's where the involvement should occur because that's when social workers start evaluating the home, the parents, the children, and making non-Indian judgements as to what is best for Indian families and their dissolution. Tribal social services people are not involved in that process, they don't come onto the scene until it's already completed by the state and the whole case is within the courts.

There are also some resolutions that were brought here by Goldy Denny which we will have copies of and that she was admonishing the people to support to oppose the regulations that are being drafted by the Bureau and to contact the Bureau indicating your opposition. Goldy also indicated that the hearings which were conducted by organizations like NTCA and NCAI were really not adequate because of time constraints. They came out very quickly so that the Indian people really did not have enough time to go in there and address the problems. Goldy also brought up the fact that the Bureau of Indian Affairs and its agents, Raymond Butler, David Etheridge, and Rick Lavis, are individuals who were opposed to the Indian Child Welfare Act before its passage and now we have to rely on these people to implement the rules and regulations. So you can see that we are relying on people who don't want the act's success.

I hope that the information that we are putting out will be very beneficial and that you will rally behind it and help us in opposing a lot of these things that are going on.

JAMES SMITH: In conclusion, I'd like to express my appreciation to the facilitators, panel members and moderators that handled the workshop sessions. I think they did a fantastic job. They had a lot of participants and they shared a lot of information. Most of all I'd like to thank you for coming, for attending the workshop sessions, for participating.

DONALD LAPOINTE: There are three additions not listed in your book. First of all, there is going to be a report on the Americans for Indian Opportunity Conference that took place in Albuquerque last weekend. We have Maggie Gover here, who is the Program Director and assistant to LaDonna Harris and she is going to address the Environmental Health Proposal: "Messing Around With Mother Nature Can Be Hazardous To Your Health And An Assessment of Environmental Impacts."

In addition to Maggie's report we're going to have a statement from Quinault Tribal Chairman Joe de la Cruz. In addition to that a report by Dr. Charles Hinslong from the American Institute of Medicine.

At this time I'd like to introduce Dr. H. C. Townsley, who is head of Indian Health Service's Mental Health Program out of Albuquerque, New Mexico. I had an opportunity to work with him on a couple of occasions and I'm sure that you'll be interested in the report he has to give.

DR. H. C. TOWNSLEY: On behalf of the mental health staff of Indian Health Service let me thank, certainly Howard Tommie, John Belindo and the entire NIHB staff, for inviting the mental health program people here.

We're pleased to see that there is evidence now of a strong emphasis and interest in mental health. Dr. Rhoades last night spoke of disharmony in mental health issues and we've long since acknowledged that this disharmony or mental disfunction in the Indian people is the number one illness manifested by many other areas that affect our lives negatively; alcoholism, drug abuse, child abuse, spouse abuse, et cetera, many of the things that will be covered in the workshop.

Most of you well know that there are very few people, not only Indian people, although there's a dismal portion of mental health problems in our Indian people, but practically no one escapes at some point in their life from feeling the pain, the agony, the despair and the misery of the emotional component of our lives.

First, I'd like to state the program philosophy of the IHS Mental Health Programs by stating that the state of mental health involves a complex interrelationship of our emotional, cognitive thinking and physical factors of man's being between his family, his tribe, the community and, in general, society at large.

In emotional terms mental health is a state of mind in which there is a sense of well-being and self-respect and in which there is a sense of freedom to act and to live up to one's potential. Behaviorally, mental health is the ability to identify and to solve problems, to make and act on one's own decisions, to work productively and to maintain satisfying relationships with others. Cognitively or thinkingly, mental health is the ability to think logically, to perceive objects as they actually are, to perceive reality or events objectively and to make minimal use of pathological defense mechanisms. Mental health also involves harmony between mental and physical aspects of one's total being, the theme you heard Dr. Rhoades elaborate on last evening.

Having said that, let me, as briefly as I can, give you an update and review of the Mental Health Programs of IHS. In many respects FY '79 has been a year of review, analysis, evaluation, redefinition, some internal strengthening, establishing linkages and careful planning. This is coming about because of an intrinsic need during this stage of program development and also because the 1979 budget allowed no new appropriations. We have been forced to reexamine our priorities and activities in light of these limited resources. Hopefully, as a result, we will emerge a stronger and more efficient service within the context of existing appropriations.

This year has not been easy but in quality it still has been good. This summary outlines just the major program trends, the activities, progress, problems and failures during FY '79 by our office.

Activities in respect to national issues: several recent national reports, including the President's Commission on Mental Health and the Advisory Committee have shown that American Indians and Alaska Natives do not have equal access to services provided other citizens of this country. The reason for this disparity is legendary. In an effort to minimize this discrepancy the Secretary, who is now ex-Secretary Califano, ordered an Indian initiative which put programs within the HEW on notice to improve their service record to Indian people. Long aware of unmet needs within the field and now newly enforced by that mandate we have worked hard to secure redirected funds and services on behalf of our people.

The results of these activities include some of the following accomplishments: Provisions for Indian tribes and groups to be named as special populations eligible for direct program services within the Administration's proposed Community Mental Health Systems Act.

It is important for you to know that this act, at least in the rough initial draft, for the first time, calls for the capability of Indian tribes to apply directly to the National Institute of Mental Health for direct mental health funding program needs on our reservations.

I won't give you any additional details because of the time, but we've worked on that at the national level for about a year. They have acknowledged it and whether or not it will be implemented into law remains to be seen.

Additional activities: With new interests on the part of NIMH, regions and states and respect to the needs of Indian people, several negotiations are presently underway to get NIMH-funded staff and services at the reservation and urban center levels. To date, however, we have been unsuccessful in developing a method for direct transfer of funds from local community mental health centers to IHS but have suggested ways of hosting staff. We've requested that the National Institute of Mental Health directly transfer $3 million in service monies for mental health needs to IHS. We've been encouraged at times by NIMH but when it gets down to signing the check the transfer has not yet occurred. They tell us the reason they cannot is because they are lacking

regulations which will permit this. I'm personally inclined to say I don't believe it, but, I think it's more polite to say I doubt it.

Our office is supporting the National Indian Board on Alcohol and Drug Abuse, you heard Al Pooley discuss that earlier, in its discussions with the National Institute of Drug Abuse, in respect to making funds and services more accessible to Indian drug abuse projects. In my opinion, and the opinion is shared by many who are knowledgeable, the National Institute of Drug Abuse has not been as responsive to the Indian people's needs as they have to the population at large. We did have a contract with NIDA and that project has been completed. Al Pooley was the project director for that. That effort produced three training manuals and we're in the process of readying them for distribution.

Also, some of you are aware that there was an HEW-HUD initiative and this has resulted in five tribes being given the opportunity to develop model family residential facilities for children and the aged. Although he is not here, I would acknowledge with pleasure that Dr. Karl Menninger of the Menninger Institute in Topeka, Kansas, was the catalyst for this project and I'm pleased and humble to say that our office provided strong support to his efforts.

Just a brief word about the President's Commission on Mental Health. The final report of this select commission was delivered this year with the director, IHS Office of Mental Health Programs, attending the presentation ceremonies at the White House. The subpanel task force on American Indians and Alaska Natives developed a special report which contributed to this population being named specifically in the final report. This special reference was much more limited that we had hoped but nevertheless it was there and it was significant.

An implementation task force was set up within HEW by the Secretary with a key representative from IHS. This task panel has recommended full appropriations for Title II of 437. The work and report of this commission has done much to keep mental health needs in prominent view of Congress and the general population. Endorsements by NIHB and NCAI and other Indian groups have urged appropriations to help meet the mental health needs of Indians and Alaska Natives. However, congressional appropriations have in no way begun to match the authorization level of 437.

A brief word about two or three of our other programs and then I'll conclude. We are pleased that the tribal health programs have shown an increased interest in mental health to the tune that a survey conducted this past year revealed that tribes throughout the nation have allocated approximately 100 positions to special mental health services. There are many more positions which have been assigned additionally to drug programs, youth services, the aged, Head Start, et cetera.

In addition, the model mental health program project, was initiated at Stewart Indian School at Carson City, Nevada, although it's a phased implementation. That program is exemplary in its ability to improve the mental health status of our Indian youth in boarding schools.

437 calls for the additional capability of IHS to develop these model dorm mental health programs and until such time as we get the money we will have to be minimally satisfied with our small efforts at the Stewart Indian School.

The Indian Children's Program. Many of you will be attending a workshop in which Roland Johnson, who's here with some of his staff, will give you additional details. We are pleased within our program to have Roland Johnson from Laguna who is now the acting director of the Children's Program.

The Regional Psychiatric Inpatient Unit in Rapid City has Dr. Robert Cary as our director. His other staff members were unable to be present, but he will be in one of the workshops coordinating in collaboration with Dr. Jerry Meketon of our office. Those of you who are from that nice area might very well have specific questions to direct to Dr. Cary.

Among other aspects of 437 we have initiated a process with the White Cloud Center and I'm pleased to see the director here, Dr. Ryan. We're hoping to have them complete, through a subcontract, the implementation of a correlation between IHS and traditional medicine practitioners. That has been grossly underfunded, incidentally, I think we only received $35,000 for such a program. This coming year we're supposed to receive a hundred and fifty or two hundred thousand. The likelihood of that occurring however remains considerably in doubt.

Surely if your interest in mental health continues by attending the workshops you will get a more complete and rounded picture than what I've been able to give you in this very brief time.

Again, in conclusion, I want to thank NIHB, Howard and John and Donald, for inviting the mental health people of IHS.

DONALD LAPOINTE: At this time I'd like to introduce Maggie Gover, the Project Director and also the assistant at the Americans for Indian Opportunity, AIO, of Albuquerque, New Mexico.

MAGGIE GOVER: I just want to basically ask for your cooperation in the continuing project and in the new phase of work that Americans for Indian Opportunity is about to undertake.

Probably most of you have been at some of our seminars and some have worked with us on some of the things that we have done in the last five or six years. LaDonna Harris, as you know, is our President and Executive Director. We've primarily focused on two phases of activities. One

is helping tribes and Indian organizations do the things that they see as necessary and vital in their own communities. The second part of that is opening up federal agencies, the business communities, educational institutions, and all that wide range of other people that you have to work with in order to function in your own community.

In doing that we started about five years ago with a program of talking about Indian control of Indian resource development. Why, if Indians own as much of the valuable resources as they do, are they still the poorest people in the country? It's because in spite of that somebody else is running their business. So we've started trying to bring some expertise and assistance to people in their own communities to take over those programs and do it themselves.

Things that have happened in the last five years I think are pretty exciting to all of us. A national kind of evolution of that as we see Indians beginning to take over control of development of their own resources. We're seeing tribes now running their own coal mines, taking over management of their own timber, all kinds of different developments that the tribes themselves are running.

In addition to that we've seen a major growth in federal programs among tribes. There's new housing coming in, there's new business, community buildings, there's new this and new that and the stresses and strains and the things that are happening to the people in the community and as a result we have come to focus on the environmental health impact of development.

Trying to figure out exactly what that means, we looked it up in the dictionary. What we found is that environment means the aggregate of social and cultural conditions that influence the life of an individual or the community. Health is the condition of being sound in body, mind and spirit.

We've tried to put together a project for the next two years focusing on assessment of the environmental health impact of development of Indian communities and the rules of the government agencies charged with responsibilities for various aspects of environmental protection and individual safety.

That basically means we're going to try to find out what's happening in Indian communities and what impact the things you are doing is having on your people. It's really easy to take uranium development, as an example, the kinds of impacts of development. We know that most of uranium on Indian reservations right now has been strip mining so you've got one immediate impact. You've got that big hole in the ground. The thing you've got is a lot of stuff going up in the air and a lot of things going into the water. You've got a lot of trucks and heavy equipment running around on your reservation where your children are playing. You get all of these things going and that's fairly easy but then you've got all that radioactivity that you can't see, can't get hold of, and we don't know what the effects are. You start looking at the federal agencies and you say surely somebody knows what they are doing with that so you start trying to figure out who is responsible and you say there are Indians working in that mine, so the Occupational Safety and Health Administration must have some responsibility.

Then you find out that there's the mine safety group. Then you find out, you think, well, if there's air and water, the Environmental Protection Agency ought to have something to do with it, so you go see them. There's an air division, there's a water division that has four separate divisions, and you can't get any one of those to talk to any of the others so they don't even know what they're doing in their own shops. Then you find out that the Indian health service is supposed to be doing testing in some kind of cooperative agreement with EPA, then you look at the water that you are putting on your crops and that doesn't fall under either Indian Health Service or EPA, but under BIA..

Then you try to find out how much water you've got, you find out that's USGS business, they're the ones doing that. What you finally find is you've got all these people doing all these things but nobody knows what the other one's doing.

What we're trying to do in this project and what we're asking your help in is to get all of those people who are doing wonderful things to come together with the Indian community and really work to identify some of those things that we don't understand that are happening to us as a result of development or failure to develop in Indian communities.

We'll be doing a series of seminars. We'll be doing some research. Our first step will be to have a group of Indian people come together with our federal agency people the first week in August to work out the details of the program.

If anybody is interested in this project I'd like to talk to you after this.

DONALD LAPOINTE: I'd like to quote from the Indian Task Force Report for the President's Commission on Mental Health: "Today is a good day to live for American Indian Natives."

We have an excellent program planned with you in mind. Thank you very much.

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Mental Health Workshops

MENTALLY AND PHYSICALLY HANDICAPPED

Moderator: Dr. George Blue Spruce, Director, IHS Phoenix Area

Facilitator: Dr. Theodore Marrs, Director, IHS Indian Children's Program

Panel Members: Betty Bitsue, Psychiatric Social Worker
PHS Indian Health Center
Chinle, Ariz.

Roland Johnson, Administrator, IHS Indian Children's Program

Joseph Pugliese, Social Worker, IHS Indian Children's Program.

Dr. Blue Spruce opened the workshops by introducing the panel members. In summary, their presentations were as follows:

Betty Bitsue: Gave a brief introduction about herself and her experience in working with the handicapped. She stated that all children regardless of age have certain basic emotional needs, and it is the responsibility of the parent to give the stimulus to meet these needs. Children express their feelings in some type of outward signs, and if you miss these signals the children could develop emotional problems.

We need to assist the handicapped in dealing with their problems, and we need professionally-trained people to assist them.

Since I am from the Navajo Area I am relating my experiences there. We do all our therapy on an individual basis, and we work with the children at home, not institutionally. We found this is most effective.

We have also found that doing this type of therapy gives us a true picture of the home and environment; provides an education for the family; allows us to relate this experience to the home life; and lets us provide therapy in the patients' native language.

Lack of funds is a problem which seriously hinders the development and expansion of programs. Right now our program is using all the resources available, including Indian Health Service (IHS) funds and other supplemental resources such as the tribe's rehabilitation program. We are now trying to coordinate all the programs.

Another problem is the lack of trained professionals who can deal with the handicapped. We also need to provide employment for the handicapped after they are trained. There is more competition for the jobs now. The handicapped need to be able to fit into the community, and employment is one of the keys for allowing them to do this.

Roland Johnson: Illustrated a need for the development of programs and services for the handicapped. Since this type of program is operational in IHS, it can be expanded to other areas with increased funding. One reason why there is a lag is because there is a continued reluctance to recognize that the handicapped can be taught to cope with their problems. Public Laws 94-437 and 94-142 have opened the doors for new, positive programs. P.L. 94-437 has enabled us to develop a residential facility (diagnostic, evaluation, treatment and planning center) in the Albuquerque area.

The center, located at the Laguana Pueblo, can house 60 youngsters with Indian parents. At this time we don't have any idea how long the treatment will be. We will be treating patients from infancy to age twenty-one.

The philosophy of the center is that the emotionally and physically handicapped deserve the right and the opportunity to become a part of society. The program will supplement any other program in the child's community. The center will use multi-disciplinary medical personnel. The center, which will hopefully become operationable by late 1981, will be purely a diagnostic, treatment, and planning project.

The center will also have a full-time outreach staff to the local Indian communities. There is no cost to the family since the facility is operated by IHS. Follow-up work is done by the outreach staff to make sure the child follows the program developed for him/her. Parents will play the primary role in determining that the treatment is followed.

Joe Pugliese: Employed as a social worker with the Indian Children's Program, which is a national program within IHS. He believes that the essential element in dealing with handicapped children is love. The Indian Children's Program has looked into different ways of treating the child. People dealing with these children have to have an emotional standard. There are appropriate and adequate ways of dealing with these children. You need to have a professional team (physical therapist, expressive are therapist, psychologist, etc.) capable of dealing with the handicapped.

MENTAL HEALTH

Moderator: Roger Jim, Councilman, Yakima Tribe, Toppenish, Washington

Facilitator: Dr. Jerry Meketon, Ph.D., Chief, Quality Assurance and Training IHS Office of Mental Health Programs, Albuquerque, New Mexico

Co-Facilitator: Robert Cary, M.D., Director, Regional Inpatient Psychiatric Unit, IHS Office of Mental Health Programs, Rapid City, South Dakota

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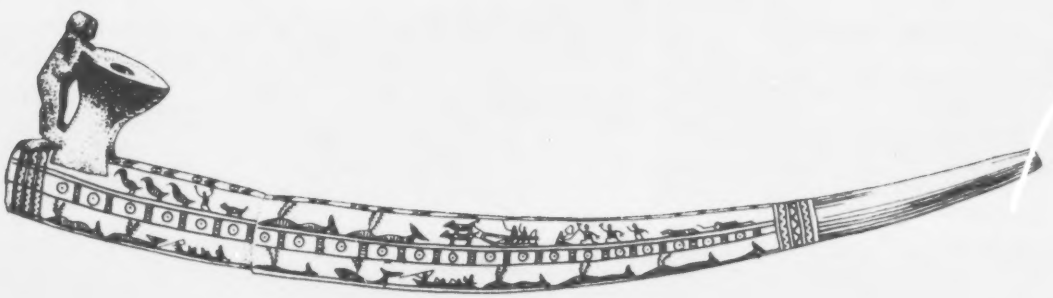
In keeping with the mission described in the opening session of the general assembly, the workshop in Mental Health attempted to supply pertinent information and sought the wisdom and guidance of the participants.

The sessions opened with three major issues for discussion. The first concerned mechanisms for obtaining increased funding for Mental Health Programs, both tribal and IHS. The second issue concerned means of bringing together the different agencies with service responsibilities to Indian people so that their resources could be more effectively used. The third issue concerned the development of inpatient psychiatric services, both short and long term.

Questions from the group were collected, discussed and recommendations were developed from them. At the second session, Dr. Townsley joined the workshop and Mr. Lindsey Williams, from the National Institute of Mental Health, discussed the programs of the institute. The following recommendations were strongly supported by the workshop participants:

1. A line item budget for contract psychiatric care must be initiated. The competition with other medical services can make all programs losers.
2. Through necessary legislation or by an internal Department of Health, Education and Welfare decision, arrangements should be made for an interagency transfer of funds from the National Institute of Mental Health to the Indian Health Service for direct community mental health services on reservations and in urban centers. The amount requested was $3 million, but this is the absolute minimum, and $4-5 million is more reasonable in terms of the needs of urban and rural programs.
3. Through a major Indian Health Service reorientation and in-service training effort, prepare, equip, and supply backup sources to IHS local facilities so that adequate care for brief hospitalizations and all alcoholism detoxification can be offered.
4. The need for continued education training resources and career development for existing mental health staff is desperately needed. It is recommended that through funding of Title I of P.L. 94-437 and the interagency cooperation of the BIA, "ADAMAHA", and IHS, a pooled resource be developed to service Indian mental health workers in the field.
5. Once again there is general agreement that the programs described in P.L. 94-437 be fully funded. Many programs simply can not go forward without these funds.
6. One of the last and strongest points made was that each Indian community can and must organize its resources to shape its own future. The various government agencies responsible for service to Indian communities will only be moved by efforts within the Indian community to mobilize them. The legal mechanisms are now available and should be used.



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CHILD ABUSE AND NEGLECT

Moderator: George Platero, NIHB Representative, Albuquerque area

Facilitator: C. H. McCracken, M.D., Maternal and Child Health Consultant, IHS Billings Area

Co-Facilitator: Carole Butler, Project Director, National Indian Child Abuse and Neglect Resource Center, Tulsa, Oklahoma

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These sessions started with Dr. McCracken giving an overview and definition of child abuse and neglect, along with some case histories for examples. He pointed out that due to modern social pressures to conform to western society, complicated by the breaking up of extended families, child abuse is on the rise in Indian families. He suggested the formation of active child protection teams in the communities.

Carole Butler gave an outline on how to form these teams by using the Suspected Child Abuse and Neglect (SCAN) approach used in Oklahoma. These teams consist of concerned individuals from the local community (i.e., doctors, lawyers, counselors, social workers, police and private citizens) to work as a multi-disciplinary team. The three facets of the team are: identification of child abuse and neglect; treatment of child abuse and neglect; and education of the public on the ramifications of child abuse and neglect.

The team should get to know each other, and find out their different philosophical outlooks. It is vitally important that they be able to work together as a unit and overlook personal differences.

Other considerations in starting these multi-disciplinary teams include:
— define the goals of the group and the roles of the professionals in the agencies represented.
— develop a working definition of child abuse and neglect. This will vary, depending on the background and customs of the community. The extremes of physical abuse and neglect are easy to define (e.g., fractures, burns, malnutrition, death). Other forms of abuse, such as psychological or emotional abuse, can be equally serious but much harder to identify.
— define the community that the program will serve. For maximum effectiveness, the community should be defined primarily by population served rather than geographical boundaries.
— identify the problems in the community. Pinpoint the greatest obstacles to the development of a quality child abuse and neglect interdisciplinary program.
— inform the agencies represented on the team of the purpose and progress of the meetings.

For cases of child abuse, long and short term coordination is needed. The short term would encompass immediate noting of suspected abuse, taking action legally, getting treatment and diagnosis, and removing the child for safety, if necessary.

The long term coordinated effort would encompass family and child counseling, encourage attendance and following of prescribed treatment, and generally encourage the family to work on the problems that are resulting in abuse of the child.

It is important to note that while the safety of the child is the primary concern, everything possible should be done to keep the family together as a unit. Placing the child in a foster home or an adoption agency should be done only as a last resort.

Butler also told workshop participants about some of the cases she had encountered working in the area of child abuse. "For a long time, I used to say that there was no physical abuse of children in Indian communities. I really believed that. I am sorry to say that I can no longer believe that because I am seeing more and more children that are physically abused. I think that it is actually increasing, but we just don't have the data to really determine this."

Child abuse cases cited by Butler included incidences of neglect, physical abuse, isolation, and sexual abuse. She described four characteristics of families where abuse and neglect occurs: (1) abuse experienced in the parent's background; (2) social isolation; (3) the occurrence of a crisis; and (4) negative feelings toward the child.

Butler briefly described the National Resource Center on Indian Child Abuse and Neglect. The center is funded through HEW and has been in operation since January 1979. The primary responsibility of the center is to gather and disseminate information on child abuse and neglect.

Dr. McCracken then went over several recommendations to improve services to Indian and Alaska Native families where child abuse and neglect occurs. Among others, these included:
-- a request for adequate staffing for Child Protective Services in Indian communities
— organization and support for child protection teams
— a request that the Bureau of Indian Affairs urge adequate staffing for child protective services in communities and in boarding schools.
— a request that IHS expand its mental health services to include services for the treatment of child abuse.

These recommendations were discussed by participants of the workshops and were adopted in resolution form to be presented to the National Indian Health Board for further action.

NUCLEAR POWER DEVELOPMENT ON OR NEAR A RESERVATION

Moderator: Violet Hillaire, Chairperson, Northwest Washington Service Unit Board

Facilitator: Andy Fernando, Nuclear Study Project Director, Skagit System Cooperative

Panelists: Karen Means, Black Hills Alliance, South Dakota

Dr. Laverne Huson, Service Unit Director, Shiprock, New Mexico

Russell Bush, Attorney, Skagit River Cooperative

Dr. Lynn Robbins, Professor of Anthropology, Western Washington State University, Bellingham, Washington

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The above panelists presented for the first time in a national Indian health forum a unique multi-disciplinary approach to the very complex area of nuclear industrial development and how it relates to Indian people and their land.

The following summaries present the essence of their various points of view.

Dr. Ruth Weiner — Environmental Scientist

Presented an overview of the U.S. nuclear power industry, which consists of three basic activities: (1) mining and processing; (2) research activities and facilities; and (3) nuclear power plants construction and utilization. In all these activities, workers and populations are potentially exposed to radiation through direct exposure, particulate inhalation, or ingestion of contaminated foods and water.

In the particular area of the Skagit River System, the unknown factor is what effect radiation has on the fish and vegetation which are traditional foods.

Karen Means — Black Hills Alliance

The alliance was created in response to citizens interest in what impact the coal and uranium mining industry would have on the population of South Dakota and what would be the long lasting effects of this industry.

Of great concern is the potential for contamination of the entire aquifer of the state of South Dakota since no one knows what the extent of this radiation contamination could be.

Water, land, air, plants, and animals are suffering the assault of these mining activities and in turn affect humans, including Indians who live in remote areas who have no political strength and are ignorant to the whole energy fuel cycle.

Dr. Lavern Huson — Indian Health Service Unit Director

Dr. Huson described the tragic impact of the uranium mining industry on the Navajo Nation. The early uranium mining industry exploited not only the land, but also the unskilled workers who were brought in from the reservation and are now dying and suffering from radiation exposure. Since 1970, there have been 31 Indians who have died of lung cancer associated in some way with mining activity — 15 miners and 16 non-miners. The average age of these deaths is 44, with the youngest being 33.

Along with lung cancer, other conditions that have been attributed to working in the mines include secondary radiation fibrosis, heart conditions, leukemia, and lymphomas.

The mines were closed in the 1960's, but mill tailings were left unstable and are being blown away in the wind or washed down rivers during spring floods. These mill tailings sometimes retain up to 85 percent of the radiation, and no one will assume the responsibility for decontaminating these areas. The entire food chain of the Navajos could be affected by radiation from these tailings.

Dr. Lynn Robbins — Cultural Anthropologist

The Navajo acted in good faith in the early 1950's and went ahead with massive strip mines and coal-generated power plants, believing that it would be economically beneficial to the tribe. The Four Corners Power Plant supplies 6,000 megawatts of electricity that provide power to five million homes in southern California and Nevada. But the tribe has not been adequately reimbursed for this mining, and efforts at litigation to recover economic losses of the past 25 years have not been successful.

Andy Fernando — Skagit System Cooperative

There have been no prior health status studies done on populations immediate to proposed nuclear power sites. Further, there are no biological impact statements prepared on the biosphere adjacent to these sites. Geologic problems such as earthquake faults and volcanos are minimized as not having any impact on the future siting of nuclear power plants.

Seven tribes are within a fifty mile radius of the proposed Skagit River Nuclear Plant site. One third of the nearby Indian families fish on the Skagit River for ceremonial and commercial purposes. And yet, in the final Environmental Statement prepared in 1978, the only reference to Indians was that "the river is not fished commercially except by Indians."

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ANDY FERNANDO (at podium), Vice Chairman of the Upper Skagit Tribe, told participants at the workshop on nuclear power development about potential environmental hazards from a proposed nuclear plant near his reservation.

Both Indian and non-Indian citizens are currently involved in a Skagit River Impact Study that will determine the health, economic, fisheries, hydrologic impact of the proposed nuclear plant on this federally designated Wild and Scenic River.

Russell Bush — Attorney, Skagit River Cooperative

Now that the United States is caught up in an energy crisis, the federal government is seeking every possible alternative to creating a national self sufficiency on energy fuels. The Indian lands have now become attractive and vital for the development of a national energy plan since 55 percent of uranium deposits are on Indian land and 40 percent of low sulfur coal is readily available on these lands.

Indians must adamantly demand that the federal government provide for the protection due them by treaty, notwithstanding concerns for national interests. The land, its contents, and living things on the surface must be protected for exploitation.

Further, the Indian Health Service acting as advocate for Native Americans must be asked or required to respond to the hazard of low level radiation on those reservations where such development is now occurring. Indian people must get into the national energy policy decision-making process before it is too late.

A risk is being imposed on the Indians without their consent and there exists no provision for them to protect themselves.

Based on discussions among workshop participants and panel members, the following recommendations were made and will be presented as a resolution before the National Indian Health Board:

1. That Indian tribes be allowed to enter the decision making process at the earliest point in situations where nuclear development will affect Indian health and welfare, and that full assessments of health impacts be made before any facility is licensed.
2. That government agencies be educated to recognize adverse health impacts through study of previous problems encountered by tribes and reservations from nuclear development.
3. That the National Indian Health Board (NIHB) insist that Indian representatives be appointed to regulatory bodies and oversight agencies dealing with nuclear development, especially in those parts of the nuclear development cycle directly affecting tribes.
4. That NIHB support Indian tribes adversely affected by nuclear power development, and where practicable, intervene on behalf of those tribes that do not possess the monetary or technical resources to prevent licensing or operation of nuclear development facilities.
5. That NIHB support compensation payments to uranium miners and dependents who have been injured or impaired as a result of radiation exposure.
6. That NIHB enlist support from the Council of Energy Resource Tribes for research and assistance to tribes affected by nuclear development.
7. That NIHB undertake studies to determine the extent of adverse impacts from secondary chemical releases or from chemicals used in extraction and processing of nuclear fuels.
8. That NIHB insist that a special IHS unit be established to research and treat health problems attributable to exposures of radiation releases in all phases of nuclear development.
9. That NIHB promote more Indian control over extraction and use of nuclear materials on reservations and inform Indian tribes how they can protect tribal members' health through use of tribal or federal law.

10. That NIHB exert pressure on nuclear regulatory and environmental protection agencies to eliminate conflicts of interest preventing effective application of laws protecting Indian health from damages of nuclear development.
11. And very importantly, that the NIHB establish a functioning working group of tribes and experts capable of monitoring the nuclear industry, conduct research radiation on health impacts, and assist tribes in protecting Indian people from adverse health impacts of nuclear developments.

BATTERED SPOUSES

Facilitator: Mel Sampson, NIHB Representative, Portland area

Panel Members: Walter Farrow, IHS Social Worker, Yakima Service Unit

Naomi Shepard, Community Worker, Department of Social and Health Services, State of Washington

Patty Nagle, Past Director, Dawson House Shelter

Tallulah Pinkham, Mental Health Worker, Yakima Service Unit

Virginia June, Psychiatric Nurses Consultant, Navajo Area IHS Office

The workshop sessions opened with a long discussion among the audience and panel members about the causes related to the battered spouse syndrome. Workshop participants also saw an interesting film about the problems of battered spouses.

The battered spouse has been a universal concern, though a silent one, for centuries. There is no race or socio-economic class of people this age old problem has not touched. The battered spouse is a major problem among our Indian population which needs to be addressed. However, the solution to the problem is a complex one with a myriad of factors to be considered.

Suggested causes of battered spouse problems include, but are not limited to, misuse and abuse of alcohol and drugs, poor self-image, unemployment, and jealousy. These problems are further displayed in frustration. Alcohol has been a major source for release of frustration, which is directly related to the social and economic problems on most reservations. For example, the unemployment rate ranges from 30-60 percent on most reservations, leaving much idle time that often contributes to frustrations.

We are greatly concerned about our Indian families, including their social, economic, and environmental conditions. Indian cultures and traditions hold in great value the roles and responsibilities of each family member contributing to the nuclear family structure.

Present problems of frustration resulting from alcohol and drug abuse, unemployment and poor self-image must be addressed in order to understand and begin to solve problems related to physical and emotional abuse.

Presently, there is no federal or state agency effectively addressing the problem of battered spouses among Indian people. There is a great need to develop comprehensive programs of support, counseling, and services geared toward the Indian culture to identify the problems and the strategies which will most effectively address this need.

The Indian Health Service, which is responsible for the provision of health service to American Indians, has not recognized nor provided the necessary programs to treat the battered spouse and there is an urgent need to establish such programs.

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Thursday, July 26, 1979

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Fourth General Assembly

HOWARD TOMMIE: Ladies and gentlemen, I call the meeting to order. This is the fourth and final session of the Third National Indian/Alaska Native Health Conference. If you will all rise, I will ask Emma Farrow to give us our invocation before we proceed with this last session.

EMMA FARROW: Creator and Master of the Universe, bless all who have given the time and effort to come to this conference, for those of you who are approaching your health concerns in a positive manner, we ask for their continued success, and for the others who have come to the conference who are skeptical that no positive changes can be made. We ask you give them new strength to be persistent in the pursuit of improved health care for their people. May all be rewarded with a measure of success that will give them the confidence to believe in themselves and their efforts.

In this International Year of the Child we ask a special blessing upon our children, now and for all time. They are your gift to us and our hope of the future. May our parents, grandparents, relatives and friends receive your grace as to teach our children the religious, cultural and traditional values of our tribes.

We thank you for the abundance of spiritual and material blessings bestowed upon us. May we live and utilize it in harmony with Mother Earth. Finally, we pray that the participants of this convention return safely to their homes and their families.

HOWARD TOMMIE: The highlights of the mental health workshops will be presented by Dr. Townsley, Director of the Indian Health Service Mental Health Program, Albuquerque, N.M.

DR. H. C. TOWNSLEY: I am going to ask Lindsley Williams to spend about 10 minutes with us and explain the Community Mental Health Centers Act because there is an aspect in it which pertains and may well impact upon the mental health needs of Indian people throughout the country, including Alaska, of course.

Mr. Williams is a gentleman I've known for about a year or so. Now, he's Acting Director of the Office of Program Development and Analysis at the National Institute of Mental Health. The Office of Mental Health of the Indian Health Service has had a level of success since our relationship with Lindsley Williams in being able to start providing some increments and services to Indian people. Prior to that time, there was a barrier that was very difficult to break through.

Truthfully, Mr. Williams has been cooperative with his program and his department, and I imagine those of you from this region are aware of the award of the community mental health center forthcoming for the Yakima people. Credit for that is due Mr. Williams and to tertiary efforts on the part of the Indian Health Service Mental Health Program, and certainly the Yakimas are the primary people to whom the credit should be given because they initiated and developed a proposal which is now functioning.

Now, I am going to ask Mr. Williams to come forward and explain the language of the Act. I think what he has to say will be very important to us for future mental health program needs.

LINDSLEY WILLIAMS: I am pleased to be here and have an opportunity to share with you the proposal that has been advanced by the Carter Administration as a means of implementing the recommendations of the President's Commission on Mental Health. The President, in one of his earlier acts in his Administration, established a commission to review the realm — the world of mental health and the programs in it. This, as you know, was chaired by Mrs. Carter and had a broad-based group of commissioners representative of both the persons in need of mental health services and service providers, representatives also of states, community organizations, and the minority groups and special populations. One of those commissioners was LaDonna Harris.

The President's Commission on Mental Health worked for about one year. Its report contained a number of recommendations relating to mental health research, mental health training, mental health prevention, stigma, and probably more relevant to this convention, mental health services.

In the specific area of services, the commission suggested that the Community Mental Health Centers Act, which has been the mainstay of federal planning for mental health services in the communities, be revamped in some significant ways.

What I would like to do is to share with you the ways in which the Department of Health, Education and Welfare on behalf of the Administration is proposing to implement the recommendations of the commission. Basically, the department has drafted and forwarded to the Congress a piece of legislation called the Mental Health Systems Act. This act would, if enacted, have five titles, the first three of which relate, but not exclusively, to state governments. If appropriations are made under these titles, we would have programming for assisting in the treatment of chronically mentally ill adults, as well as children, prevention programs and assistance to the states for the development of their management capacity.

A fourth title is in the area of community programs and that's the one which I would like to spend a moment or two with you on at this time.

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That title would provide authority for developing awards similar to community mental health centers, but with considerably more flexibility. It would also, for those communities which were not able to launch a fully-comprehensive approach, allow those communities to initiate segments of service with an end objective; although, not necessarily something one would have to accomplish within one or two years of a comprehensive program. But it would allow the development of specialized programs for one or another special population. That latter is of particular relevance to the Indian people.

The bill also, if adopted, would help us to overcome some statutory barriers that have served to curtail, although not preclude, interaction between community mental health centers and the Indian Health Service and through the Indian Health Service to the Indian people.

I point particularly to sections 630-A and 630-B, which are important for this group and for the National Indian Health Board to consider in the course of their study of this bill and their forwarding to the Congress of any comments they may have on it. We have until now not been able to award grants from the National Institute of Mental Health as directly as we would like to the Indian Health Service. We have always been able to award grants to nonprofit organizations that were otherwise qualified to receive grants, and this would include Indian tribal groups or urban Indian organizations. However, there have been instances in which the people of the Indian communities have asked that the services be provided by the Indian Health Service; and this has provided the lawyers in Washington lots of fun. It's also been something of a dilemma.

Now, to overcome that dilemma, we have put into this proposed legislation the following two sections: 630-A, at the request of an Indian tribe or tribes as defined by the Indian Health Care Improvement Act, or any urban Indian organization also as defined in that act. A grant may be made under this act to the Indian Health Service or any institution, clinic, or unit thereof, on the same terms and conditions as supplied to nonfederal entities for any project to serve members of respectively such tribe, tribes or organizations. The second part of this is 630-B: Any grant under Subsection A may be made for a project serving members of an Indian tribe(s) or urban Indian organization even though the area in which those members reside is included in two or more mental health service areas of the state. The latter section deserves some comment.

Under the Community Mental Health Centers Act, you may be familiar with the term "catchment area." If you are not, let me state briefly that it is a geographical area containing approximately one hundred to two hundred thousand people and up until now grants have been made exclusively to a single organization within a catchment area. It is, in a word, a franchise arrangement. The section that I just read to you would acknowledge the special circumstances faced by Indian tribal organizations in some parts of this country; particularly, in the Bemidji area, in which, there are small clusters of people living in different parts of the state. Up until now, we would have had difficult dealings with those groups and under the proposed act we will have more flexibility.

Finally, I would like to comment on a new element of the state plan requirements, and I do so with some trepidation, but nevertheless, I think it is worth commenting on. The states have been required up until now to provide some degree of state planning with respect to community mental health centers. This will continue in a revised form in one of the revisions that was made consistent with the recommendations of the President's Commission, which found a number of underserved populations, both of special mental health needs, as well as different ethnic, geographical and cultural characteristics. The states will not begin to have to address the mental health needs of what are called priority populations. It is pertinent to this organization to know that the Administration's bill, the Mental Health Systems Act, includes in the definition of priority populations American Indians and urban Indians as those terms, again, are defined in the Indian Health Care Improvement Act.

In terms of your advocacy role, you will find this legislation being considered in the Senate as S-1177 and in the House of Representatives under the banner of HR-4156. I would like to invite your group to study this legislation and to comment on it. I hope that you will find that you can support it. I would be pleased also to accept criticism in whatever form you wish to address it.

I might comment that in the community services portion of the legislation under Title IV, there are two particular elements of high relevance to you. The one I mentioned was initiation grants; and the second one is so-called linkage grants. We have established linkages between community mental health centers and community health centers thus far. Under the community health center legislation, we have not had our own authority to provide funding to organizations providing mental service to allow them to develop added mental health services. Under the linkage grant concept, this possibility would become something to be considered by people across the United States.

DR. H. C. TOWNSLEY: I would truly urge all of you who have an interest in this, and I assume that's the vast majority of you because it is important legislation, as it may well impact upon the future mental health capability of NIMH and Indian Health Service, to write Mr. Williams' office, send in your support, if you are so inclined. I certainly do recommend that and/or your criticisms, whichever.

With that, let me begin again in the Mental Health Workshop review sessions.

To report on the child abuse and neglect sessions, I am going to ask Carol Butler to come forward. Carol is Director of the National Indian Child Abuse and Neglect Resource Center of the Native American Coalition of Tulsa.

CAROL BUTLER: I would like to say that in both of the child abuse and neglect workshops yesterday, it was standing room only. We had a lot of interaction between the participants and the facilitators. The moderator of our session was George Platero, who is the NIHB representative from the Albuquerque area. Dr. McCracken, from the IHS Billings area, was the facilitator and I was the co-facilitator of that workshop.

The workshop presentation, discussion, and questions revolved around the fact that child abuse and neglect is as much a problem in Indian and Alaska Native communities as it is anywhere. Jurisdictional issues and lack of resources in the communities further complicate the situation. Child abuse and neglect is emotionally, and can be physically, scarring. Because of childhood experiences, the abused and neglected child is likely to be ineffective as a parent. Therefore, this creates an unending cycle of child abuse and neglect.

We discussed in great detail the fact that the Indian Child Welfare Act is now a reality. The final rules and regs have not been disseminated. Many of you attended the public hearings that were sponsored by the Bureau of Indian Affairs and gave your input. We hope that these were considered in terms of what the final rules and regulations will ultimately say. So, it is now a reality and it is up to us to implement that in the best fashion for the welfare of our children.

We also discussed the problems of child abuse and neglect in these areas: Number one, physical abuse; number two, emotional abuse; number three, psychological abuse; number four, sexual abuse. Discussion came through strongly that elimination of child abuse and neglect must be accomplished through a team approach and community involvement. This is very, very important as we commence to implement the Indian Child Welfare Act. We also know that it is going to take a lot of time, and input and a tremendous amount of effort from all of us who are interested in the welfare of our children.

Seven resolutions were presented by the workshop to be considered by the NIHB and those were — and I will list them as number one being — we hope that the standards will be developed for adequate staffing of child protective services, regardless of the agency providing these services. Number two, policies preventing the use of interagency, interdisciplinary teams be resolved. Three, in those places where the Bureau of Indian Affairs provides child protective services, that they recognize that the services be a

MEL SAMPSON: The battered spouses workshop also had a tremendous turnout for both sessions. We were quite pleased with the interest that was generated.

We opened the workshop with a movie entitled, "Battered Women, Violence Behind Closed Doors." This movie appeared to be totally explanatory and hit basically every element that we proposed to cover within the workshop. It hits areas such as, what is battery — meaning that battering the battered spouse is comparable to the child situation — there are, basically three types: physical, emotional, and mental.

The group also became interested in the funding aspect. They were interested in knowing how to start a basic program. Since it was quite apparent that there isn't a federal agency specifically addressing this situation, there was concern about the comprehensive aspects of developing a program. The concern also arose and the concern probably hasn't been contained within the Tribal Specific Health Plans, as to where does the battered spouse program belong? Does it belong priority over their administrative trust responsibilities. Four, that the IHS consider the provisions of mental, medical health and medical social services to families where abuse and neglect is occurring. Next, that the director of the IHS direct his mental health services branch to place high priority upon the provision of appropriate therapy to children who have been abused and neglected; and also, the same type of therapy to their families. Next, that drug and alcohol workers be trained in managing the effect of parental alcoholism and neglect upon their children. Last, that where children are abused in boarding schools and other institutions caring for Indian children, that there be a mechanism for bringing a halt to abusive practice. This is the end of my report and I thank you very much.

DR. H. C. TOWNSLEY: Those recommendations are well worth noting, and I am sure NIHB will consider those, as well as additional recommendations from a write-in viewpoint that you in the audience may have. Certainly, the future lives of the children who are abused are terribly impaired and their effectiveness as adults and parents is greatly reduced. An abused child frequently does indeed become an abusive parent. I would particularly emphasize the aspect of the BIA boarding schools. As many of you know, there is a tremendous amount of hidden sexual abuse of young Indian ladies in the boarding schools; unfortunately, this comes to our attention and not enough has been done. We, as well as BIA, must not skirt this issue, but look at it directly and make amends and do something in the area of prevention.

Now, to follow in the proper sequence, it would be appropriate to call on Mel Sampson, an NIHB representative who was the facilitator for the battered spouses workshop.

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within an existing program element or agency or should there be an area separately for the situation?

The area which probably raised one of the gravest concerns was whose responsibility is the battered spouse syndrome? Who does it belong with? Does it belong with the family? Is it a tribal responsibility? What segments of law enforcement should be responsible for this? Is it the federal agency, the state agency, the county or the tribal law enforcement segment? This in turn leads you right into the legal systems and ramifications that you get involved with as far as jurisdictional concerns and issues. When you are trying to address a person in this situation, again, is it a federal, state, county or tribal jurisdictional issue?

Then we got into the quality and kinds of people that are needed as far as the program personnel with any program in operation or being proposed — by this I mean the professionals, the volunteers and members of the family, even some outsiders within the area. There was a lot of concern despite the fact that there apparently isn't a concentrated effort but an indication surfaced that this is probably something that a great amount of attention should be given in the areas of training and education.

I will read a statement that was developed by the group. "There isn't an all-out or even a noticeable effort for the prevention or the apprising of training people in the law enforcement area of the situation. The medical staff, the legal and social workers, the clergy and educators, and the community and others maintain silence and have not instigated an effort to serve."

With that, I would like to read just a short summation of what came out of the workshop, and I would like to pay tribute also to the people who served as panel members. We had Walter Farrow, who is a social worker with the Indian Health Service operating out of the Yakima Service Unit; Naomi Shephard, who was a community worker with the Department of Social and Health Services for the State of Washington; Patty Nagle, who has been instrumental in formulating and establishing some shelters for battered spouses; Tallulah Pinkham, who is also a mental health worker with the Yakima Service Unit: she addressed primarily the kinds of involvement that the Indian cultural areas play within the syndrome; then, Virginia June, who is the psychiatric nurses consultant with the Navajo Area Indian Health Service, and she quite extensively covered the psychological aspects of how the family structure is affected by the battered spouses sydrome.

Now, I will read the summation: "The battered spouse has been a universal concern, though a silent one, for centuries. There is no race or socioeconomic class of people this age-old problem has not touched. The battered spouse is a major problem among our Indian population which needs to be addressed. However, the solution to the problem is a complex one with a myriad of factors to be considered. Many suggested causes of battered spouses are — but are not limited to — misuse and abuse of alcohol and drugs; poor self-image; unemployment, and jealousy. These problems are further displayed in frustration, and alcohol has been the major source for the release of frustration, which is

directly related to the socioeconomic problems on most reservations. For example, the unemployment rate ranges from 30 to 60 per cent, leaving much time that often contributes to frustration."

When I say "we," I am obviously talking about the people that are represented at the workshop who participated, and I might add, quite actively.

"We are gravely concerned about our Indian families, their social and economic and environmental conditions. Indian cultures and traditions hold in great value the roles and responsibilities of each family member's contributing to the nuclear family structure. Present problems of frustration resulting from alcohol and drug abuse, unemployment, and poor self-image must be addressed in order to understand and begin to solve the silent abuse" — and I quote "silent abuse recognized as an area requiring immediate attention."

"Presently there is no federal or state agency effectively addressing the problem of battered spouses among our Indian people. There is a great need to develop comprehensive programs of support, counseling, and services geared toward the Indian culture to identify the problems and strategies which will most effectively meet the need. The Indian Health Service, which is responsible for the provision of health services to American Indians, has not recognized, nor provided, the necessary programs in a comprehensive manner to treat the battered spouse. The whole family is negatively affected in such an environment. There is an urgent need for the Indian Health Service to establish effective programs for the battered spouse syndrome."

"We request the National Indian Health Board to immediately proceed with any and all measures to assure that Indian Health Service will be notified and will positively respond to this health and social problem."

With that, I would like to thank all the people who came to the workshop. We appreciated your input and concern.

DR. H. C. TOWNSLEY: I just received the summary report on the Mentally and Physically Handicapped Workshop. It is only a couple of pages, and with your permission I will read it.

This workshop was also well attended. The workshop was moderated by Dr. George Blue Spruce, Director of the Phoenix Area IHS. Betty Bitsue, who is a psychiatric social worker on the Navajo reservation, gave an excellent presentation on her experiences in working with the handicapped, the lack of services for the handicapped, and her recommendations and dealings with the problems associated with the care of handicapped Indian children.

Her presentation was followed by a presentation by Roland Johnson and Joe Pugliese, staff members of the Indian Children's Program. Mr. Johnson elaborated on the Indian Health Service project to construct a National Indian Children's Mental Health Diagnostic, Treatment and Planning Center near Albuquerque, N.M. It was explained that the center will be purely a diagnostic facility, which will be staffed with a multi-disciplinary, special trained, experienced and sensitive professional team, which will develop medical and educational plans of treatment for handicapped Indian children. The center, a cooperative project between IHS and the BIA, will be constructed on a site 18 miles west of Albuquerque on lands leased to IHS by the Pueblo of Laguna. It will service Indian children from birth up to 21 years of age, whose handicap appears to be so complex that they cannot be properly diagnosed in the home community. The center will serve as a prototype with a very distinct possibility that the center's operation would be expanded to other areas of the country.

Mr. Pugliese informed the attendees of the present operation of the Indian Children's Program. The ICP with its limited staff of specialists is presently providing outreach services to many Indian communities, schools, community health care providers and staffs of residential care centers. The outreach services consist of diagnoses, evaluation, and treatment planning in the areas of occupational and physical therapy, psychology, special education needs, speech therapy, expressive arts therapy, and psychotherapy. Because of funding and staff limitations, existing services must be limited to a specific geographic area presently consisting primarily of Arizona and New Mexico. As staff and monies are available, the geographic area of service will likewise expand.

There was a good exchange regarding the need for upgrading services for the handicapped and a very favorable reaction to the planned construction of the Diagnostic, Treatment and Planning Center and the desire for expanding outreach services. The morning group unanimously urged the passage of a resolution supporting the efforts of IHS to construct the center and expand overall services to handicapped Indian children.

We will now ask for the summary report on the general mental health workshop — Dr. Jerry Meketon of my staff.

DR. JERRY MEKETON: The thing that I remember best about the general mental health workshop was the people, the warm feelings among all that were present and the desire on my part to know every one of them better. It was very clear to me, despite the fact that I have been with the Indian Health Service many years, I am unaware of all of the good things that are happening out in the communities, and all of us need to know more about what each of us is doing. So one of the things I plan to do when I return to Albuquerque is to make sure that we have a newsletter that is open to everybody working in the field of

mental health; that will give us a means to see one another in person as frequently as we can and, at least, to get our ideas, our problems, and most of all, our solutions out to the other people who are working in the field.

The recommendations that came out of the two workshops I will not present as a formal presentation, but I think it will get the major ideas across. The first one was through necessary appropriations, legislation, or by internal Department of HEW decisions that we need to make arrangements for an interagency transfer of funds from the National Institute of Mental Health to the Indian Health Service for direct community mental health services on reservations and in urban Indian centers.

Lindsley Williams, who was in the afternoon session, is in complete agreement with that idea. The problem he has is the problem we have; which is, how do you get the funds? So we leave that open for the people who know how to do these things to see that the monies that are not being utilized fully in the community health centers somehow get to the people that they need to serve, the Indian people.

Another recommendation was that in the new Community Mental Health Systems Act a provision for tribes to receive NIMH funds directly for services be included. Before Lindsley left, he asked if I would remind the National Indian Health Board that some correspondence directly to the National Institute of Mental Health, and particularly to Congress, might help that along.

Another recommendation that had a fair amount of discussion both in and outside of the workshop was that the BIA, IHS, NIMH, NIAAA, NIDA, and all the other various initialed agencies who have the obligation for direct services, education and training to the Indian people; get together and, instead of spreading their resources thinly and sometimes in ways that make it difficult to discover exactly what they do have to offer, work cooperatively to form, perhaps, something like a human services college without walls that would actually support all the local programs where mental health people in the field are trying to get specific training and to have it done where they live and work. The possibilities are there, and in many instances the facilities, but what is lacking is a cooperative effort among these different agencies.

Another recommendation involved the need to design and implement an effective system for inpatient psychiatric care which would include effective use of local IHS facilities for brief psychiatric hospitalization — and this is not an easy task. Most of the local service units would welcome doing this, but they don't have the staff, plus of the staff they have many are not trained to accommodate mentally ill people. In addition, there are very few mental health staffs that can back up the efforts of the local service units to have brief hospitalizations. But something needs to be done to establish a regional IHS psychiatric facility for short-term and intermediate-term stays or, at the very least, to ease the way for hospitalizations at the state community health centers or private facilities.

The final recommendation received was that the Indian Health Service needs to have separate contract funds for psychiatric patients. As it is right now, contract funds for mental health purposes are drawn from the general funds, and as a result, have to compete with physical problems. This should not be the case. I wouldn't want to put anybody into the position of having to make a moral choice between taking care of those who were recently in an accident or someone who needs a kidney transplant and whether a psychotic patient who cannot be cared for at home gets to a facility that could care for him. It's just not the kind of decision that should be imposed on anyone, and certainly separate mental health funds would go a long way toward solving it.

DR. H. C. TOWNSLEY: That completes the specific aspect of mental health. The next summary report is that on nuclear development on Indian reservations. The moderator was Violet Hillaire, Chairperson of the Northwest Washington Service Unit Board. Violet, will you please come forward to give us a summary report on that.

VIOLET HILLAIRE: I would like to just give you some background information on why this issue appeared on the agenda of the National Indian Health Conference. Within my service unit representing four tribes and on one of the rivers of our tribes, they are proposing to put two nuclear power plants. When the Three Mile Island incident occurred, was when we became aware and started investigating what was going on. There is a group of people working on that from the Upper Skagit Tribe. They really couldn't get any support or interest from the Indian people because they were unaware of the possible hazards. They came to our service unit health board to ask for support. They had a proposal to the Indian Health Service to do a study to determine the possible health hazards that such a plant could pose. Indian Health Service said they could not fund it because they only provide direct care delivery services. So that meant that they couldn't do anything until after problems have occurred.

But anyway, our morning workshop was well attended and we got a lot of input from the participants — all the way from tribes that had uranium mining on their reservation. One participant said that some of their Indian miners go home wearing their work clothes and, therefore, exposed their families to small doses of radiation. I thought that was a good concern, and he wanted to know how he could help these miners understand that they have to take precautionary

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measures for the welfare of their families. So it was suggested that they take it back to their tribal health departments or CHR's.

The recommendations were that the National Indian Health Board follow through on some of these important points and that we have it all in writing. But one that I thought that was really important was that we should send someone to certain meetings so they will know what we are doing and saying and get their support so they don't think we are trying to override the tribal governments. The other one was to develop legislation. Another was dissemination of information. Most of the Environmental Impact Statements are left in the area offices of IHS or BIA and that's the extent of it and why tribes can't get the information.

I want to read the recommendations that will be addressed in the resolutions just to highlight the points of concern. One addressed in our resolutions asks that Indian tribes be allowed to enter the decision-making process at the earliest point in situations where nuclear development will affect Indian health and welfare. And that full assessments of health impacts be made before any facility is licensed.

Number two, that government agencies be educated to recognize adverse health impacts and study previous problems encountered by tribes and reservations from nuclear development.

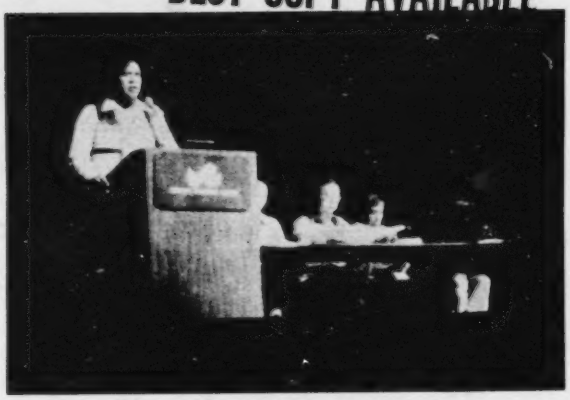
Three, that the National Indian Health Board insist that Indian representatives be appointed to regulatory bodies and oversight agencies dealing with nuclear development, especially in those parts of the nuclear development cycle directly affecting tribes. The other one was that we do something about getting a representative on OSHA.

I would just like to share what one of the participants said in our workshop. He said that he already feels like he's dying. He was from one of the Montana tribes. He wasn't aware of all of these potential health hazards.

DR. H. C. TOWNSLEY: Just one comment in closing. Again, our gratitude to NIHB, not only for inviting our mental health staff to this important conference, but even more importantly for the emphasis on mental health needs of Indian people. This is our charge and goal, to try to improve the harmony and peace and the well-being of Indian people.

HOWARD TOMMIE: Thank you, Dr. Townsley, we appreciate your participation. Moving right along, we have a report from the Resolutions Committee.

DONALD LAPOINTE: We have a summary of the resolutions submitted to the Third National Indian/Alaska Native Health Conference. Some of them were similar to those passed at the Second National Indian/Alaska Native Health Conference held in Albuquerque last year. In fact, some of the



NIHB CHAIRMAN HOWARD TOMMIE addresses general assembly during final day of the conference.

resolutions we received were almost identical to those we passed a year ago.

A resolution was received from the Fort Hall Business Council that the provision of the Contract Care Regulations which requires Indians to exhaust all alternative resources before they are eligible for contract care be reappealed on the grounds that it diminishes Indian rights and imposes unfair burdens on Indian people.

A resolution was received in regard to a consortium of Indian Health Manpower Development to resolve that Public Law 94-437 be amended to provide grants to higher education institutions to run demonstration projects on ways to improve the admissions and retention of Indian students in health professions training.

A resolution from the patients rights workshop resolved that the National Indian Health Board take action to insure implementation of patient rights at all levels of the Indian Health Service. The National Indian Health Board adopted a resolution to this effect at the Second National Indian Health Conference.

A resolution was received that existing Indian health manpower be strengthened and expanded to the early development stages from grades one through twelve. We received another one in regard to the same subject, submitted by Bill Wilson, asking expansion of existing health care recruitment programs with emphasis on establishment of a career pathway starting in the elementary grades and continuing to secondary and higher education.

There was a resolution in regard to the Indian Health Care Improvement Act, P.L. 94-437, that adequate levels of funding be appropriated in order for the federal government to fulfill the intent of the law and to honor its trust responsibilities to the American Indian and Alaska Native population.

There was a resolution allowing for a research design and funding of community mental health centers specifically for American

Indian and Alaska Native communities according to their local and cultural needs.

A resolution in regard to the elderly to resolve that the National Indian Health Board urge the commission of the Administration on Aging and the Secretary of Health, Education and Welfare to move in a prompt and expeditious manner so that various tribes and tribal organizations and the state and local agencies can resolve the rules and regulations of the Comprehensive Older Americans Act of 1978, Title VI.

In regard to Emergency Medical Services, the workshop resolved that the National Indian Health Board and Indian Health Service find ways to insure recurring funding for Emergency Medical Service programs.

Participants of the child abuse and neglect workshop and the Fort Hall Tribe resolve that the National Indian Health Board should work to establish standards for staffing Child Protective Agency Services and to work to remove federal procedures that obstruct interdisciplinary efforts to address child abuse and neglect problems. It should be urged that the Bureau of Indian Affairs establish a separate office on child protective services.

Again, the Fort Hall Business Council resolves that Indian Health Service should conduct an analysis of the Minnesota Multiphasic Personality Inventory Test to determine its appropriateness for use on the reservation. The Fort Hall Business Council resolves that Congress provide direct funding for Title VI of the Older Americans Act.

From the 1980 Census workshop, a resolution previously adopted by the National Indian Health Board at its 1978 health conference. The recommendation, be it resolved, that the Third National Indian/Alaska Native Health Conference establish an American Indian/Alaska Native Advisory Committee and that once established that the National Indian Health Board would work with that committee.

There are position papers received from area intertribal councils. They ask support from the National Indian Health Board so that these position papers can be used in writing resolutions. From the Intertribal Council of Michigan a position paper requests National Indian Health Board's endorsement for a proposed diabetes program.

Several of the resolutions received were on issues affecting local health boards. One asked endorsement of NIHB on the planning and construction request for Chinle hospital.

There was a request for the endorsement of federal recognition of extended communities of the Kickapoo Tribe of Texas; and also for implementation of the Canoncito Tribal Specific Health Plan.

A resolution was submitted by the Oklahoma City Area Indian Health Service Advisory Board. It was of local concern regarding Indian Health Service recognition of the authorities and responsibility placed upon the Oklahoma City Area Indian Health Board.

On local issues, the Shoshone Bannock Tribe submitted several resolutions. They are asking for National Indian Health Board support of the Most In Need Program, a program of the National Institute of Mental Health. They are asking for support of the proposal that's to be submitted by Shoshone Bannock — a standardization study of the Minnesota Multiphasic Personality Inventory, and support of the Shoshone Bannock efforts in the study. They are also asking for direct funding of Title VI of the Older Americans Act for their tribe. In addition, they submitted a resolution of national concern asking a $25 million appropriation for the Older Americans Act.

On health care for Indian college students, the National Indian Health Board has addressed this on several occasions. We had a further request for the issuance of student identification cards entitling them to college and university health care while they are in school. I am referring back to resolutions that were adopted by the National Indian Health Board in San Diego in 1972, and in Baraga, Mich. in 1974. The rising cost of health care is at an all-time high. We are requesting that the Indian Health Service make continual efforts to maintain adequate funds to provide health care for eligible students attending college. This is going to be submitted as a recommendation for change in the Indian Health Care Improvement Act.

A recommendation came out of the battered spouse workshop to resolve that the National Indian Health Board urge Indian Health Service to establish a program to address the service program relating to the battered spouse syndrome.

The traditional Indian medicine workshop resolved that traditional medicine be recognized by the health system and be supported by the federal government and that a national medicinemen's association be established.

The Bethel Service Unit Native Health Board in Alaska, a comprehensive health care facility which will be ready for occupancy in 1984. In addition to increased staffing, they are asking for staff housing. They are asking the National Indian Health Board's support to provide additional housing serving the new facility.

Again, regarding the battered spouses, there is an urgent need for Indian Health Service to establish effective programs. We request the National Indian Health Board to immediately proceed with any and all measures to assure that Indian Health Service be notified and positively respond to this dire health and social problem.

There was a workshop resolution in regard to nuclear power development on or near reservations which contains several points of concern.

They are asking that the National Indian Health Board insist that Indian representatives be appointed to regulatory bodies and the oversight agencies dealing with nuclear development, especially in those nuclear development sites directly affecting tribes, and that the National Indian Health Board support Indian tribes adversely affected by nuclear power development. And that the Indian tribes are allowed to enter into the decision-making process at the earliest possible date in situations of nuclear development which will affect Indian health and welfare. And that full assessments of the impact on the health of Indian people be made before any nuclear power facility is licensed.

HOWARD TOMMIE: The resolutions and the resolution committee often have difficulties in resolving correct wording. So it was decided that our board members will take the resolutions home and consult with the areas they represent; and then we will act upon them at our next board meeting as the Chairman of our Resolutions Committee has indicated.

Not to prolong the closing of the conference, but the Alaska Native representative, Ethel Gonzales, asked if she may make a comment on the conference itself. So with your indulgence and patience, the Alaskan group has been involved in many important health issues in their area and would like to share with us some of the things that they had to go through, as well as comments on the conference.

ETHEL GONZALES: Ladies and gentlemen, brothers and sisters, I won't take too much of your time. First of all, I want to commend a few hearty souls that have survived these very trying four days. Our Alaska group just wanted to share some of their observations and thoughts with you at this time. As you know, I function as Vice-Chairman of the National Indian Health Board, and I also served on the planning committee that worked in developing this health conference. However, I am addressing you right now as Chairman of the Alaska Native Health Board. Our Alaska delegation has been meeting each and every day throughout the conference at five o'clock. Last night in our meeting, they gave me very specific instructions to address very specific issues. So I am coming to you as their spokesman to share these thoughts.

Our Alaska delegation at this health conference is composed of 35 people; some of them have been in attendance at all three health conferences. And then too, we have many for whom this is their first health conference, but they all arrived at the same consensus in their evaluation. The level of expertise that was available at many of the workshops was not applicable to Alaska. I know to many of you here today this brings a negative response in terms that Alaska is always saying they are special; and we picked up on that, too. When we would ask questions in the workshops — well, that didn't apply — and we who reside and live in Alaska, this is our home. We are very familiar with that because every piece of federal legislation that affects our Indian health program is not specific to the needs up there. We are always trying to fit a square peg in a round hole, so to speak. We always have to work around some regulations that are not applicable up there.

We didn't see any new and innovative approaches at any of the workshops. We feel that in three years surely something new could have developed. In fact, as one of our board members said, there were the same old issues, without solutions; even some of the same old jokes that we recognized from three years ago. The Alaska group felt that real, vital issues were being skirted in the workshops; and we could never get down to the nitty-gritty of working things out or even addressing them. They felt a lack of real commitment from the IHS personnel who participated in the workshops. They felt that was indicated by the early departure of many of our top IHS personnel.

We would like to approach this kind of a relationship from a partnership perspective. We felt if 638, indeed had any validity, this was the only approach we could take. The Memorandum of Agreement that we have developed in Alaska utilizes this. So we tried to approach our method of dealing with problems, health issues, with IHS personnel, sitting down and looking at them and trying to work them out as equal partners. Certainly, this was not reflected here.

It was only two years ago that our Alaska Native Health Board, composed of 12 members, traveled to Rockville. We developed a special proposal for funding so that our board could get training right in IHS headquarters. We spent four days there right in the offices so we could learn how the system worked. We felt that as board members the only way we could operate was to understand it thoroughly.

We spent four days there, but to give you an indication of where we are coming from when I am making these comments about training and about workshops and about learning and about sharing. On the first morning, we were sitting down as a group and going over the agenda and determining what we wanted to learn, what our needs were. Art Thomas, who is the Tribal Affairs Officer in Rockville, came in very cheerful and very energetic and sat down and said, "Well, we are ready to go. We have all the people lined up and this is what we are going to do." The Alaska group, as I told you before, has a very strong sense of independence, but they also communicate very well. Everybody looked at me as chairman to get this straightened out and get us on the right foot immediately. So I asked Mr. Thomas if he would mind waiting outside the door about 10 minutes until we got ourselves organized. This was very upsetting and he let us know that there had never been a tribal group that

had asked IHS personnel to please wait outside the door until they got themselves organized.

When he came back in, we had finalized the list of the things we wanted and needed. When we requested that the training come from that perspective because we had spent a great deal of money coming down and we needed instruction, and rather than waste their time as IHS personnel giving us the regular standard overview of programs to please address the specific issues. Well, it created some confusion, but they did comply. They went back and reorganized things.

As a result, we came away from those four days of training with precisely the knowledge and the information that we wanted. But it would not have come about had we not taken the initial stand to give that direction.

I guess what I am trying to say is that the dialogue has to be two ways. And we had hoped this would be true here at this health conference and we just did not see that happening. I think it would have been helpful to all of us as Indian people if we had a little bit more input in giving some direction as to what your needs are in terms of training and information.

The Alaska Native Health Board recognizes a need for very strong and decisive leadership through the National Indian Health Board. They also recognize that that strength and that decisiveness can only come if they have the support and the direction of the people they represent. From our observation, there is something really lacking in that setup. We accept the responsibility, as I hope all the Indian people will, that in order to be a strong and effective national organization, you have to participate right at the local level and let your needs be known and give direction as to where you want to go in terms of health. We really believe that once Indian people are coming from that perspective, there really isn't a single barrier that you can't overcome. But it takes that decisiveness and commitment, and we were very sad to see that this had not started yet on a national level.

We just wanted to leave the thought that perhaps, even though this is the last day of conference, when you go home to your areas and to your reservations and to your tribes, now you can speak in a positive way of the things that can happen on a national health level — beginning at the local level, with your recognition that all the National Indian Health Board needs is the support and the direction of the people it represents.

We recognize that the National Indian Health Board could only do so much to create and bring about a successful health conference. I know from sitting on the planning committee, we really tried to bring together all the elements to make this conference what you people would want. But we recognize too, that a large element of responsibility in any successful conference lies with the participants. They have to care, and they have to want it to happen also. The Alaska group would just like to leave this small thought with you before we adjourn today: Indian people have always cooperated from the perspective of pride and independence and self-reliance. When you recognize that in yourself, and capitalize on it and utilize it in every aspect of your life, even in the health planning and educational things that affect your people, you find that you can plan and operate and manage programs from this perspective of pride. You have then the freedom for innovation, for flexibility, for progress and you can really respond to the needs of your people.

But when you operate from the perspective of fear, and by this I mean, the fear of losing federal funds, fear that you may not be in contract compliance, when all your energies are stifled by those kinds of fears, then you are losing complete and total sight of your goal and your direction. Instead of using those energies for the improvement of health care for your people, you are finding yourself getting lost in trying to react to the direction and requirements of Indian Health Service in the federal funding source. It hurts our people when we operate from that level.

We recognize the need to search for every other possible alternative resource available to our Indian people. When we are always looking for the federal government to provide the dollars, to determine the priorities, to administer the programs, we are really cheating ourselves and our people. When I first went to Washington, D.C., when my board sent me down to offer testimony at the appropriations hearings, it was a very, very trying experience for me personally. An atmosphere of suffocation and justification, when the health programs that wouldn't be available to our people in such dire need just did not sit right and I feel our Indian people should not have to be in that position. But once you become complacent and self-satisfied with your health programs nothing will change. We sit back and say, "Well, we've got this many dollars and these kinds of services are available and we are very thankful for that." And coming from that perspective, instead of looking at all of the innovations and needs and all of the things that can be done, then we are cheating ourselves again.

Our board in Alaska has set as a priority of this coming year the investigation of alternative resources that are available to us Alaska Native people. That includes per capita assessments, third-party payments, possibly, Health Maintenance Organizations. We are also going to be looking to our for profit organizations to see if something can be worked out in the very complex tax structure that exists. But we are going to put high emphasis on ourselves as individuals who are independent and self-reliant and who can bring about changes and want changes. Because we see people in our villages who still do not have access to any health care whatsoever. We see our

young people — the suicide rate in Alaska, I think, is probably the highest across the nation.

All of us on the board are aware of the isolation and the life that exists that brings these things about. So all of our efforts, as a board, are to change and bring into existence new programs which are still needed.

We also recognize that the federal government is never going to be responsive to all of those needs. We accept the responsibility ourselves to look to ourselves to bring those about. As we told you a couple of days ago, when Agnes Nichols offered the invocation, our board is not special in any way; our people come from all walks of life, and have different educational levels. We found out that we have a common basis in our belief in ourselves and our belief in the spirit as a source of strength and love. We would like also to leave that message with you as Indian people; it's latent in all of us. It's there inside, that strength and that capability and that pride and that self-reliance is in every one of us. We just need to remind each other once in awhile. And that's what we wanted to do this morning.

When we are faced with problems in Alaska, we used to just identify those problems, sometimes that was hard to do, even to recognize the problem; okay, verbalize and let it be known — we've done that, but this past year we have come one step further. We now actively work at the solution and not just one solution, but alternative solutions, so when we come to Indian Health Service or to any other federal program, we are saying, "These are our problems. Here are some possible solutions we think will work." And we find out operating in that perspective, things just kind of work and happen much easier.

So we came up with recommendations last night at our meeting, which will be submitted to the National Indian Health Board in resolution form from the Alaska delegation. I'll outline these recommendations to you. Number one, in resolution form, we directed the National Indian Health Board to establish a technical resource pool that would be available to all areas on request. By this, we meant professional people with expertise in the areas of federal contracting, procurement regulations, Indian law, because the system we are dealing with is very complex. It is becoming more so as time goes by. When we have to work on a partnership level with contracting officers and people in the Indian Health Service system, you have to understand precisely what those regulations mean; what the contract system is; what the regulatory process is. And in order to do that, we really need help from people expert in those fields, otherwise, we are short-changing ourselves and the people we represent. So that was one recommendation, that this resource program be established and be available to all the areas across the country, so that when any area board is running into problems that fit into any of these areas, it can just call for help and get it.

The second recommendation by resolution was to direct the National Indian Health Board to develop a comprehensive board training program for all area boards. In the workshop that was conducted on the status of area boards, we could hear people saying, "We need help in this; we don't know what this is about. If somehow we can learn, we can get moving." The health board is where the direction for change begins.

In order to have committed, knowledgeable and trained board members, they have to have access to that knowledge. It doesn't come with experience; you can sit on a board for 10 years, and if you are not going to learn and have people teach you, you can't progress and you can't change — in the present system, that won't work. So this was the recommendation and we feel it should be a nationwide effort. We are not talking about bylaws and constitution and parliamentary procedure and how to conduct a meeting; we are talking about federal funding procurement, we are talking about communication, we are talking about developing ourselves as Indian people so we can speak out on issues with confidence, we're talking about that kind of training. We think it can be utilized nationwide.

We went through a session of training in Alaska and it completely turned our board around. We are able to deal with things with a little more confidence. We are still learning all the time, but we are developing confidence as time goes by because we know that training is a recognized element for our existence. We have continual training going on, it's not one time, or once a year. At every meeting we try to have some aspect devoted to training in some area. We would like that to be available to area boards across the nation because you need that in order to bring about those changes. And once that training has begun, you can share the common problems and gain encouragement from each other.

The third recommendation that the Alaska group made was that the National Indian Health Board establish a task force for seeking health care alternatives. The reason why we did this was we felt there was a need to look for other sources. Certainly, we are always hearing about backlash and how federal funding is going to be limited. So we need to start looking. We should have done this a long time ago to look for all alternative resources and also within ourselves; so our people will have an element of choice and the available health care; so they won't have just one place to go or one type of program, but they will have the element of choice.

The fourth recommendation that the Alaska group made was that a cost analysis and economic delineation be undertaken of IHS area office costs. We need to know these costs. We need to know if there is efficient and effective use of federal dollars. Asking for more dollars and more funding isn't always a solution to getting a better program. We have to utilize those dollars in

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the most expedient way. We are requesting that this cost analysis be undertaken so we'll have some idea where our Indian health program dollars are going.

A fifth recommendation was the establishment of a task force for development of criteria for implementing 638. And that's another area in which we hope the Indian people will not become complacent. 638 is not working the way we would want it, but we just can't sit and not do anything about it. And certainly, it is not going to happen if we don't start ourselves as Indian people and say, "We want this implemented, so that we are recognized as partners in this relationship."

Those are the recommendations that came from the Alaska group. They wanted me to explain them to you and share them with you. We would like to express our appreciation to the Northwest area for their hospitality to us. Personally, I have fallen in love with this area of the country; it's so peaceful.

I just wanted to say to the people I know in this area, thank you for the work and hospitality and just to extend our appreciation for the country you live in. Also, to the NIHB staff, our Alaska group wanted to say thank you for all the work you have done in this conference. And each of you as conference participants, we would just like to share these things with you to extend our feeling of love and let you know we appreciate this opportunity of meeting with each one of you and sharing these things. We hope that in the months to come we won't be isolated and that we will hear from you from time to time.

HOWARD TOMMIE: Some of the other board members asked if they could make a comment. So at this time, Lawrence Snake from Oklahoma.

LAWRENCE SNAKE: I am not going to hold you too long. I just want to thank the Northwest tribes for hosting this conference. I want to thank the people that participated in preparing the food. The dance program was really good. I would also like to thank the facilitators and the NIHB staff and the board members who are here, but I especially want to thank very sincerely all of you people who attended this conference and I want to wish you very well throughout the year. And I also want to wish you a safe journey home.

HOWARD TOMMIE: A fine gentleman from California wanted to thank all the participants, as well as all of the staff, and all of the people that worked with this conference, Timm Williams.

TIMM WILLIAMS: I would just like to express our thanks to all of those that made this conference available and possible for us to get together and communicate. I think that I can only reaffirm what Ethel has already said; as the California delegation does have some concerns about the conference and its goals.

Many of the board members say California is a unique part of the area in dealing with health and, even though I am from California, I think I would like to reaffirm to all of the Indians and the Alaska Natives my commitment to all of you as a National Indian Health Board member to respond to your requests, to do what you want us to do as the National Indian Health Board, and to make it your advocate, and in some places, to defend and in some places to take the affirmative and move forward with our health programs against those who would like to dominate and keep us under control.

The California delegation, a large one, felt that the workshops were a little extensive in the sense that we covered a lot of items and we are

hoping that next year in the conference we can zero in on the target areas and set some priorities, whether it be legislation or health care delivery, and come to some resolves and with some force from our Indian people who are concerned about health.

The California group would like to offer for your consideration the plan of getting our area health board directors together and setting up some kind of funding mechanism for them so that the area health board directors , who do all of our work in those areas and who are much closer to the problems than many of are as members, would have the availability to get together and maybe to match ideas and to offer one another suggestions that would support each other so that we are all in the same boat heading for the same goals of delivering health care services to our people.

We would like to have you take home this thought that the National Indian Health Board become a stronger advocate for you, and the only way that we can see that begun, as Ethel has already said, is that the National Indian Health Board would have to look for other sources of money because they are just like the rest of us in the sense that we are in the fear that our funds will be cut off if we speak too loudly against those who fund us. And the ones that fund us are the same ones that deliver health care services to you.

I want to leave you with this thought that my grandfather left with me. As I deal with my own people all my life, and when I say my own people, I mean the Indian people of America and Alaska Natives. We were walking down a pathway together; I was about nine years old, and there was a bug crossing the crossway. My grandfather said:

"Reach down and help the bug on its way." And I did. He said, "Now, do you know what you have done?" And I said, "Yes, I helped the bug across the path." He said, "Yes, and now a bird might eat the bug and you might feel badly because the bird has eaten the bug. You sort of put him there for the bird to eat, but you must remember that the Creator created the bug for birds' food, he didn't create it for you to step on."

And I apply that to my life as I work with my people. I think that if I have some knowledge, I am not any bigger than those that have less; if I am stronger, I am not any stronger than those who have less; and it is my position, if I have more knowledge to share it with those who have less; and not to walk on them. If I am stronger, I am to help them, not to walk on them. So my life has been dedicated to strive to help everybody and to think of myself as equal to anybody coming from any walk of life, at any level in life wherever they may be, because I am no greater than that bug.

HOWARD TOMMIE: In the agenda of this conference it says, "Conference Wrap-Up and Closing Remarks by the Chairman," which is me, but I think the wrap-up has been pretty well put together by Ethel and the gentlemen who just spoke.

The only thing I would like to say is that the National Indian Health Board can only provide a vehicle such as the national conference. During the conference we looked for ideas and suggestions. And I think much of the criticism of the conference can be applied in our planning for the next conference that the board will be deciding on within the next few months.

It has to be a two-way street. If you have ideas, I think the board would be willing to listen and put them in the program.The vehicle is there and we will continue to push the vehicle, whether it is a conference, whether it is a workshop, whether it is something at the local area. Any suggestions or recommendations would be very welcome starting now.

As far as the recommendations, I come from an area that is very cautious about a centralized responsibility towards Indian people or in an area to the reservation. We will review the recommendations that Alaska has given to us, but the national board has gone on record that the centralized type of operation was not feasible as far as program development and resources. The main objective, I think, the board looked at about three or four years ago was the fact that each area had a responsibility, each area knows its own needs, each area should develop its own resources, and the board would be able to support it in its endeavor to resolve their issues within their areas. I personally support that because in my area, the USET organization did not have a program management or resources that tribes themselves can operate. But there is a fine line as to what an organization can do for a tribe and the local areas can do for themselves. So the board will be looking at those recommendations very carefully.

I think that Indian self-determination, right down to the individual, is very real in our lives because we know what our needs are. If there is a mechanism that can be applied to the local area, then that's what we support in my area. I know that a lot of people question — well, then what is the NIHB responsibility — the responsibility is pretty well spelled out in our constitution and bylaws to support the vital needs of the Indian people on the reservation. There is a fine line as far as program management or development of resources at a centralized level — the areas which request assistance that can be beneficial to the areas. I think this type of action has been approved greatly by the board.

Many other people do not have a total understanding of the function of the board. We have 11 members who meet quarterly.

The board has a staff in Denver. You have the address on your programs. Our main function is to gather information and support different

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FOLLOWING ADJOURNMENT OF the Third Indian/Alaska Native Health Conference July 26, several attendees take final moment to confer before heading home.

areas. We are heavily involved with the board of the Indian Food and Nutrition Resource Center and we were involved with the feasibility study of the American Indian School of Medicine, and other activities which the board chose to coordinate.

About a year ago, the board adopted positions on many of the important issues raised within the last few years such as sterilization and abortion. The board also adopted a position on National Health Insurance. You can write our office in Denver and we would be more than willing to send any of these position papers to you.

We are also involved with other organizations such as NCAI and NTCA and we have coordinated our efforts hoping we can support them or they can support us. Many of the items in the workshops are still of great concern.

We also have been asked by the Department of Interior for input on the Indian Religious Freedom Act. Coming up in the future will be the IHS oversight hearings and also energy resource development considerations.

There are a lot of items that are left open for us to look at such as the Tribal and Urban Specific Health Plans.

Going back to the local and area health boards, we do have some concerns as to what kind of unity we have, as far as the health board and its tribal affiliations. We do have a couple of areas — my own and Aberdeen — which have dissolved their area health boards. We did have a consultation with the Aberdeen area and they are going to try to resolve the area health board situation.

The next conference will be decided upon in a few months. During that time I think that many of the issues that are being presented, you will probably hear them again. I don't think it is wrong to have to reaffirm yourself as to what position you took, or if you change your position, then it should be known. This is why you will often see an issue brought up again.

The concerns expressed about the workshops have been recorded and the national board will be looking at them. I would like to say that we will review them and put them in resolution form. Then the resolution will be forwarded to the respective agency. We have oftentimes had to pressure these agencies for a response but we have got results from the resolutions we have presented, or an explanation as to why an issue is not resolved, or an explanation as to why it cannot be done. We have always tried to inform the American Indian people of resolutions presented to the board.

In closing, I think the board will be looking forward to another conference. We will try to gear in on some of the resolutions and I think that some direction or results will be accomplished.

So at this time, I will declare the conference adjourned until we call another and we thank everybody for being here.

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Resolutions Adopted in Conjunction with the Third National Indian/Alaska Native Health Conference*

*Adopted by the National indian Health Board at its Winter Quarterly meeting in Tucson, Ariz., January 29, 1980.

Resolution 1-80-B

HEALTH MANPOWER

WHEREAS, Indian Health Manpower initiatives request by the Secretary of Health, Education and Welfare unanimously recommended that the following be an amendment to the Indian Health Care Improvement Act, P.L. 94-437 and added as another section.

Section 107(a) In order to encourage regional or national public or private health or educational institutions and Indian professional entities to admit into professional training and/or place substantial efforts in the retention of Indian of Indian students, the Secretary acting through the service, shall make grants to these institutions or entities for purposes of demonstrating capacity to utilize, in various combinations, Section 102 through 106 under Title I in productive and meaningful health manpower development programs.

Section 107(b) Priority for grant awards will be to those institutions or Indian professional entities who have demonstrated a prior commitment to Indian professional training in medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health nursing, or allied health professions: and/or who are interested in developing curriculum modules of special importance to American Indian health interests.

Section 107(c) Deals with appropriate authorization;

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board request that Indian Health Service, the Department of Health, Education and Welfare and the United States Congress act on the above recommendations.

CERTIFICATION

It is hereby certified that at a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD
NON-PROFIT
SEAL
COLORADO

110

Resolution 1-80-C

FEDERAL RECOGNITION OF THE KICKAPOO TRIBE

WHEREAS, the Kickapoo Tribe of Oklahoma is seeking federal recognition of an extended community of the Kickapoo Tribe of Oklahoma; and

WHEREAS, the Business Committee of the Kickapoo Tribe of Oklahoma sent delegates to the Third National Indian/Alaska Native Health Conference, July 23-26, 1979, to act as official emissaries of the Tribe in seeking participating tribal support of the federal recognition of the approximate 635 enrolled Kickapoo tribal members living in or near Eagle Pass, Texas; and

WHEREAS, supportive letters have been presented by DHEW, Indian Health Service, Oklahoma City Area Director and U.S. Department of the Interior, Bureau of Indian Affairs Shawnee Agency Superintendent;

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board endorses the efforts of the Kickapoo Tribe of Oklahoma in seeking federal recognition for its people separated by geographic boundaries and asks the Department of Health, Education and Welfare to extend services available to other federally recognized tribes to these Indian people.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

Resolution 1-80-D

MOST IN NEED PROGRAM

WHEREAS, despite the positive efforts of Fort Hall Human Service System Personnel, it has been noted that relatively few children with emotional and behavioral problems are able to receive total adequate care for those disorders; and

WHEREAS, within the population of children and youth under 18 years of age who are in need of services, there exists a substantial group that suffers, in addition to or because of the severity of their emotional and behavioral problems, conditions interfering with their normal growth and development, as well as difficulties in gaining access to care; and

WHEREAS, such children and youth residing within the Fort Hall Indian Reservation meet the general criteria as "Most In Need" and are therefore a target population of the "MIN" program as sponsored by the National Institute of Mental Health, Department of Health, Education and Welfare;

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board support the proposal made by the Business Council of the Shoshone-Bannock tribes for Development of Model Human Service Networks for "Most In Need" American Indian/Alaskan Native children and youth; and

BE IT FURTHER RESOLVED, that such proposals be made, as appropriate, to the Health Services Administration, Department of Health, Education and Welfare for program support and technical assistance as required to improve the quantity and quality of the delivery of services to those children and youth identified as "Most In Need".

CERTIFICATION

It is hereby certified that at a regular meeting of the National Indian Health Board in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

Resolution 1-80-E

STANDARDIZATION STUDY OF MINNESOTA MILTIPHASIC PERSONALITY INVENTORY

WHEREAS, it has been demonstrated that the use of certain psychological testing instruments such as the Minnesota Miltiphasic Personality Inventory (MMPI) have extremely limited applicability with persons having been raised on the Fort Hall Indian Reservation; and

WHEREAS, these limitations have been determined to be due to certain cultural influences prevailing at Fort Hall which consistently results in wide score variations from those standards currently in use to validate such test results; and

WHEREAS, the Indian Health Service, Portland Area Office, concurs with these observations and have expressed an interest in providing the necessary funding and program support to enable the Shoshone-Bannock Tribes to conduct a standardization study of the MMPI in order to improve and otherwise facilitate the effective usage of this testing method at Fort Hall;

NOW, THEREFORE BE IT RESOLVED, by the National Indian Health Board that such a standardization study be conducted in accordance with accepted professional standards of practice; and

BE IT FURTHER RESOLVED, that the National Indian Health Board support the proposal made by the Business Council of the Shoshone-Bannock Tribes of the Fort Hall Indian Reservation to the Portland Area Office requesting such financial and technical assistance as is necessary to carry this project through to a successful conclusion.

CERTIFICATION

It is hereby certified that at a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

113

Resolution 1-80-F

PATIENTS BILL OF RIGHTS

WHEREAS, the National Indian Health Board in its Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978 passed Resolution 2-78-S entitled:

REQUESTING IHS FUNDS FOR THE TRAINING OF TRIBAL PATIENT REPRESENTATIVES; and

WHEREAS, the patients bill of rights has not been widely publicized and actively enforced, there exists a need to implement a grievance mechanism to be established to hear and respond to patients complaints and concerns;

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board work with Area Health Boards in writing and implementing a patient Bill of Rights; and

BE IT FURTHER RESOLVED, that Indian Health Service should provide funding for patient representatives and the necessary training programs, tribal health employees, and Indian health boards in order to implement a patient representative program.

CERTIFICATION

It is hereby certified that at a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

URBAN INDIAN HEALTH CARE

WHEREAS, the input of both urban and tribal groups is necessary and desirable to obtain a full comprehensive health program offering quality services in sufficient quantity and rendered in a culturally acceptable manner to American Indians and Alaskan Natives; and

WHEREAS, appropriation by Congress the full funding authorized under P.L. 94-437, Title V, to enable the establishment of continued operation and/or expansion of urban Indian health programs is desirable; and

WHEREAS, priority consideration for funding under Section 330 of P.L. 95-626, Urban Health Initiative (UHI), for establishment, operational and expansion of funds with revision of geographic service area criteria to enable Urban Health Initiative affecting Indian population more meaningful; and

WHEREAS, the Indian Health Service contract care services should extend services to all Indians regardless of residence with increased funding levels, enabling IHS to fund all urban Indians;

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board request that Indian Health Service and the Department of Health, Education and Welfare and the United States Congress act on the following recommendations:

Extension of coverage of material and child health under Title V, Family Planning Title X, of the Public Health Service Act, Section 787, priority consideration, health career opportunity programs; and

A recommendation that urban Indian populations receive priority consideration for National Health Service Corporation (NHSC) assigneer; and

Updating Urban Specific Health Plans when 1980 Census Bureau information is available; and

Extension of Title V, authorization of 1984.

CERTIFICATION

It is hereby certified that at a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

115

Resolution 1-80-I

AMENDMENT TO TITLE XX OF THE SOCIAL SECURITY ACT

WHEREAS, Title XX of the Social Security Act is a resource for social services which the tribes should utilize; and

WHEREAS, these resources are available only by going through the state which is inconsistent with tribal sovereignty; and

WHEREAS, the need for social services has been increased with the passage of the Indian Child Welfare Act;

NOW, THEREFORE BE IT RESOLVED, that amendment be made to Title XX of the Social Security Act in order to allow for direct funding to tribes and Alaskan Natives.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

Resolution 1-80-K

HEALTH CARE FOR INDIAN COLLEGE STUDENTS — IDENTIFICATION CARDS

WHEREAS, the National Health Board in its regular meeting held in Baraga, Michigan on June 3-7, 1974, passed resolution 6-74-B reaffirming resolution 12-74-C requesting Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) "to provide the additional health care for the students at these institutions of higher learning, and that supplemental funds be made available to cover this cost and not affect present Indian Health Service or Bureau of Indian Affairs budget"; and

WHEREAS, the cost of health care is at an all time high; and

WHEREAS, the contract care monies are not sufficient to meet the health needs of Indian people.

NOW, THEREFORE BE IT RESOLVED, that Indian Health Service develop a program for college students whereby eligible students attending universities and colleges away from reservations and Indian communities are issued an identification card guaranteeing health care benefits similar to the Employment Assistance Programs under the Bureau of Indian Affairs; and

BE IT FURTHER RESOLVED, that Indian Health Service make a continual effort to maintain adequate funds to provide health care to all eligible students attending universities and colleges away from reservations and Indian communities to receive on-site health care.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

117

Resolution 1-80-L

INDIAN HEALTH SERVICE PROFESSIONAL PRIORITY SYSTEM FOR: CONSTRUCTION, RENOVATION AND MODERNIZATION OF HEALTH FACILITIES

WHEREAS, as instructed in the fiscal year 1979 INTERIOR APPROPRIATIONS CONFERENCE REPORT the Indian Health Service has developed a professional priority system for construction, renovation and modernization of health facilities to serve American Indian and Alaskan Natives;

WHEREAS, the priority system has been developed using data available from current long-range construction plans; and

WHEREAS, the priorities have been established on the basis of need and have been developed by health professionals within Indian Health Service; and

WHEREAS, the Committee in making recommendations on the Fiscal Year 1980 Budget, had adhered to this priority system; and

WHEREAS, it is the intent of the Committee to follow the newly established priorities in the allocation of funds for construction of health facilities.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board support the efforts of the Committee acting according to recommendations of the Interior Appropriations Conference report in establishing priorities for Indian Health Service professional priority system for construction, renovation and modernization of health facilities.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

Resolution 1-80-M

REDIRECTION OF OPERATION FUNDS FOR INDIAN HEALTH SERVICE TO INCLUDE EMERGENCY MEDICAL SYSTEMS IN A RECURRING FUNDING CATEGORY WITH EMPHASIS ON TRAINING TRIBAL EMERGENCY MEDICAL SYSTEMS PERSONNEL AND ESTABLISHMENT OF FULL-TIME EMERGENCY MEDICAL SYSTEMS FIELD COORDINATORS

WHEREAS, the Emergency Medical System has made tremendous strides in American Indian/Alaskan Native communities in recent years; and

WHEREAS, American Indian/Alaskan Native communities have come to depend on the life saving service provided by Emergency Medical Services; and

WHEREAS, the majority of current funding is non-recurring funding subject to termination.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board and Indian Health Service move swiftly to secure appropriations and/or redirect operational funding category with special emphasis on training for Tribal Emergency Medical Systems personnel and the establishment of full-time Emergency Medical Systems Field Coordinators.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

Resolution 1-80-N

TRADITIONAL INDIAN MEDICINE

WHEREAS, the traditional Indian religion is the foundation of Indian culture; and

WHEREAS, the traditional Indian religion and health care system are inseparable with Indian culture; and

WHEREAS, the First Amendment of the United States Constitution and the American Indian Religious Freedom Act, P.L. 95-341, requires that federal departments and agencies, and others responsible for administering federal law comply with the federal policy to protect and preserve for American Indians their inherent right of freedom to believe, express and exercise the traditional religions.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board request that traditional Indian religions be recognized as a health system of an Indian tribe; and

BE IT FURTHER RESOLVED, that the National Indian Health Board request federal agencies to cooperate with traditional Indian medicine to promote better health for Indian people; and

BE IT FURTHER RESOLVED, that the National Indian Health Board research and/or develop, when requested, methods to foster the integration and blending of traditional and modern medicine.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD
NON-PROFIT
SEAL
COLORADO

Resolution 1-80-O

DIRECT FUNDING OF TITLE VI OF THE OLDER AMERICANS ACT TO INDIAN TRIBES

WHEREAS, the Shoshone-Bannock Tribes, Inc., has been distressed and concerned about the inadequacy of supportive services provided to the Shoshone-Bannock Elderly Nutrition Project through the existing service system; and

WHEREAS, where such services are being provided, they generally follow criteria established for members of the non-Indian population, which do not fulfill the needs of its Indian elderly to live out their lives according to their own accustomed cultural, emotional and nutritional needs; and

WHEREAS, Indian tribes have an inherent sovereignty which has been acknowledged and affirmed by the United States; and

WHEREAS, direct funding would allow the tribes to plan, maintain and operate the programs that directly affect the tribal members in accordance with P.L. 93-638, the Indian Self-Determination Act.

NOW, THEREFORE, BE IT FURTHER RESOLVED, that the National Indian Health Board support the Shoshone-Bannock Tribes' efforts to obtain direct funding of Title VI of the Older Americans Act and advocates that approach for all Indian tribes; and

BE IT FURTHER RESOLVED, that $24,000,000 be appropriated for direct funding to Indian tribes, under Title VI, the Older Americans Act.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

REQUIRING THE OKLAHOMA CITY AREA INDIAN HEALTH SERVICE TO RECOGNIZE THE AUTHORITIES AND RESPONSIBILITIES PLACED UPON THE OKLAHOMA CITY AREA INDIAN HEALTH BOARD, INC., BY THE MEMBER TRIBES OF OKLAHOMA AND KANSAS

WHEREAS, the Oklahoma City Area Indian Health Board, Inc., is supported by thirty-four (34) federally recognized tribes; and

WHEREAS, the Oklahoma City Area Indian Health Board, Inc., is recognized as the advisory body of the Indian Health Service, Oklahoma City Area Office; and

WHEREAS, the Indian Health Service, Oklahoma City Area office, has not utilized this representative body in the capacity in which it was intended; and

WHEREAS, the Indian Health Service, Oklahoma City Area Office, did not consult the OCA Indian Health Board in the determination of FY 80 CHR allocations; and

WHEREAS, the distribution of CHR resources for FY 80 are inadequate to effectively meet the health care of the Indian people of the Oklahoma City Area; and

WHEREAS, The OCA indian Health Board desires to actively participate in the allocation of CHR resources for FY 80 and all subsequent years.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board fully support the Oklahoma City Area Indian Health Board, Inc., in its efforts to develop and commend to the Oklahoma City Area Indian Health Service the criteria for equitable allocation of CHR resources for the Oklahoma City area.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

122

Resolution 1-80-Q

NEW BETHEL COMPREHENSIVE CARE FACILITY

WHEREAS, the new Bethel Comprehensive Health Care Facility will be ready for occupancy in 1980; and

WHEREAS, the additional staffing of the Bethel Comprehensive Health Care Facility has not yet been approved by the United States Congress; and

WHEREAS, the needed staff housing has not yet been funded and authorized by the United States Congress; and

WHEREAS, the staff housing and additional staff are needed to provide adequate health care to the 20,000 people of the Yukon Kuskokwim Delta Region.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board assists the people of the Yukon Kuskokwim Delta Region to improve their health care services in the new Bethel Comprehensive Health Care Facility by:

1. Petitioning the Congress and President of the United States to provide 119 additional positions making a total of 265 health care workers; and

2. Petitioning the Congress and President of the United States to lease or otherwise provide 173 more units of housing to house the health care workers in Bethel Alaska.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

Resolution 1-80-R

ADEQUATE STAFFING OF CHILD PROTECTIVE SERVICES

WHEREAS, the child protective service agencies in most Indian and Alaskan Native communities are inadequately staffed in terms of appropriately trained workers, as well as, the number of workers for the case load.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board either directly or through other arrangements, develop standards for staffing child protective services in Indian and Alaskan Native communities; and

BE IT FURTHER RESOLVED, that the National Indian Health Board, either directly or through other arrangements, promulgate these standards and request that BIA, tribes, or other agencies providing services in the Indian and Alaskan communities adopt these standards; and

BE IT FURTHER RESOLVED, that the National Indian Health Board request that use of federal funds in Indian and Alaskan Native communities for social services be contingent upon the recipient meeting these standards as a minimum.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

PUBLIC LAW 93-641

WHEREAS, the Idaho Department of Health and Welfare has informed the Shoshone-Bannock Tribes that the funding for the Shoshone-Bannock Alcohol and Drug Project, which is received directly from NIAAA is currently subject to termination because of the failure by the State of Idaho to comply with P.L. 93-641, the National Health Planning & Resources Development Act of 1974 and its regulations; and

WHEREAS, it does not appear that the Idaho Legislature is taking measures that would immediately remedy the situation; and

WHEREAS, the Congress of the United States is currently considering legislation that will affect the Shoshone-Bannock Alcohol and Drug Project and possible other tribal health programs under P.L. 93-641; and

WHEREAS, the Shoshone-Bannock Tribes desire to establish its position with respect for P.L. 93-641 and the relationship between Health Systems Agencies, established thereby, and Indian tribes or inter-tribal organizations.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board supports the P.L. 93-641 amendment offered by the Shoshone-Bannock Tribes; and

BE IT FURTHER RESOLVED, that all federal dollars directly awarded to or contracted with the Shoshone-Bannock Tribes be exempt from compliance with P.L. 93-641 entitled the National Health Planning & Resources Development Act of 1974.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

Resolution 1-80-T

P.L. 93-638

WHEREAS, the Alaska Native Health Board is a representative of Alaska Native people in health related matters; and

WHEREAS, the Native people of Alaska do not see active and decisive action occurring to a plan to fully implement P.L. 93-638; and

WHEREAS, the timely implementation of P.L. 93-638 is of the highest priority to the Alaska Native people; and

WHEREAS, close monitoring of the planning for and implementation of P.L. 93-638 is not currently being provided.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board be directed to obtain appropriate funding and initiate a task force which is representative of the Indian and Alaska Native people that is charged with the duties of:

(1) Developing criteria for evaluating the planning for implementation of P.L. 93-638;

(2) Having the criteria reviewed and approved by groups representative of the Indian and Alaska Native people;

(3) Evaluating the planning for and implementation of P.L. 93-638 against the approved criteria;

(4) Preparing recommendations for improving the planning for and implementation of P.L. 93-638; and

(5) Publishing and circulating to all appropriate persons, groups, organizations and agencies a copy of the evaluation results and recommendations.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

Resolution 1-80-U

ECONOMIC DELINEATION OF AREA OFFICE COSTS

WHEREAS, the Alaska Native Health Board represents the twelve regions of the State of Alaska; and

WHEREAS, there has been demonstrated throughout this conference the need for stronger leadership and greater supportive efforts to the areas by the National Indian Health Board; and

WHEREAS, spiraling costs of health services diminishes an already inadequate flow of dollars available for the provision of health care to American Indian and Alaska Native people.

NOW, THEREFORE BE IT RESOLVED, that a cost benefit analysis be undertaken by the National Indian Health Board to determine whether area offices and the national office of Indian Health Service are utilizing congressional monies appropriated for services to Indian and Native people area office costs in an effective and cost efficient manner.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

Resolution 1-80-V

DEVELOPMENT OF A COMPREHENSIVE TRAINING PROGRAM FOR ALL AREA BOARDS

WHEREAS, the Alaska Native Health Board represents the twelve regions of the State of Alaska; and

WHEREAS, there has been demonstrated throughout this conference the need for stronger leadership and greater supportive efforts to the areas by the National Indian Health Board; and

WHEREAS, the needed changes to bring about an improved health status to all American Indian and Alaska peoples can only transpire when area boards work effectively to bring it about.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board develop a comprehensive training program available to all area boards; and

BE IT FURTHER RESOLVED, that the training include but not be limited to the Indian Health Service system and history, health care alternatives, corporate structures and advantages, communication and all federal legislation affecting Indian health.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

Resolution 1-80-W

ESTABLISHMENT OF A TECHNICAL RESOURCE POOL

WHEREAS, the Alaska Native Health Board represents the twelve regions of the State of Alaska; and

WHEREAS, there has been demonstrated throughout this conference the need for stronger leadership and greater supportive efforts to the areas by the National Indian Health Board.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board develop a technical resource pool composed of professionals with expertise in the areas of Indian law, government contracting, and regulatory processes; and

BE IT FURTHER RESOLVED, that this professional expertise be available to the areas served by the National Indian Health Board.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

REPEAL OF ALTERNATE RESOURCES SECTION OF CONTRACT CARE REGULATION

WHEREAS, Part 36, Title 42, Subpart C, Section 3623, paragraph (f) of the Federal Regulations, entitled "Contract Health Care Services" states:

(f) ALTERNATE RESOURCES Contract health services will not be authorized by IHS when and to the extent that, alternate resources for the provision of necessary medical services are available and accessible upon application of the individual to the alternate resource; and

WHEREAS, that provision discriminates against members of the Shoshone-Bannock Tribes and other tribes of the Northwest who are unable to seek inpatient care from IHS hospitals since there are no IHS hospitals available to them, (which means that an additional burden is placed upon the members of tribes which do not similarly affect tribes fortunate enough to avail themselves to IHS inpatient facilities); and

WHEREAS, the provision deteriorates and goes against the specific relationship between Indian people and the government of the United States as expressed in treaty obligations, the Snyder Act, and long standing procedures wherein the government has agreed to furnish medical and educational assistance to Native American people, we strongly feel that there is a legal and moral obligation on behalf of the government to provide programs especially for Indian people meeting their special needs consistent with their background and culture; and

WHEREAS, alternate resources such as the Department of Health and Social Services (Welfare), discourage, rather than encourage, minorities and Indian people from achieving needed medical services. The importance of programs especially designed to reach Indian people with their severe health problems is well recognized by the Indian Health Service and is reflected in culturally relevant health education, CHR, PHN, traditional medical practitioners and other programs; and

WHEREAS, many of our people do not have transportation, resources and language ability, nor do they have life styles compatible with the rules and requirements imposed by alternate resources such as the Department of Health and Social Services for successfully making application for medical care. The regulatory provision will, therefore, deprive many of our people of needed medical care; and

WHEREAS, the provision of the regulations will tend to offset and diminish the apparent need for services as a component of the Indian Health Service budget process,

therefore, it is clear to us that this provision tends towards elimination of the Indian Health Service as our major resource, advocate and partner in health care.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board calls for repeal of the provisions regarding alternate resources under Contract Health Services of the Federal Register dated August 4, 1978.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

13i

CHINLE SERVICE UNIT PLANNING MONIES

WHEREAS, the National Indian Health Board in its Second National Indian/Alaska Native Health Conference held in Albuquerque, New Mexico, February 12-15, 1978, passed Resolution 2-78-U entitled:

"ASKING THE RELEASE OF PLANNING MONEY FOR THE CHINLE SERVICE UNIT HOSPITAL"; and

WHEREAS, there exists a need for construction monies for the Chinle Hospital project to be reprogrammed to cover needed staff housing needs as well as housing for construction workers, because of the remote site of Chinle Hospital:

Chinle Service Unit Health Board recommends that the currently appropriated three million dollars of construction monies reflect reprogramming one-half million dollars into needed housing construction; and

WHEREAS, the House Appropriations Subcommittee on Interior has approved a nine million dollar construction appropriation for Fiscal Year 1980; and

WHEREAS, Indian Health Service, Regional Office of Facility Engineering and Construction and the Chinle Hospital Construction Manager estimates that fifteen million dollars is needed to assure uninterrupted construction during FY '80:

Chinle Service Unit Health Board recommends that Congress appropriate fifteen million dollars for FY '80 for Phase II construction of the Chinle Hospital rather than incurring the cost of inflation by delay; and

WHEREAS, the Chinle Hospital Steering Committee (CHSC) a voluntary community group working with the Chinle Service Unit Health Board has applied for a Community Development Grant from Indian Health Service:

Chinle Service Unit Health Board asks that Indian Health Service fund the Community Development Grant request of the Chinle Hospital Steering Committee to fund consultants to work with the aforementioned Steering Committee, staff and community in the development of Chinle Hospital; and

WHEREAS, the National Indian Health Board hereby reaffirm resolution 2-78-U and supports the additional recommendations of the Chinle Service Unit Health Board and the Chinle Hospital Steering Committee in their efforts to improve the health care delivery system to the Indian people.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board requests that the above recommendations be worthy of congressional review.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

Resolution 1-80-CC

BUREAU OF INDIAN AFFAIRS RESPONSIBILITIES FOR INDIAN CHILD WELFARE ACT

WHEREAS, the Bureau of Indian Affairs (BIA) does not accept child protective services as a priority in relation to the administration of the BIA's trust responsibilities thereby creating an inadequately staffed child protective service in many Indian and Alaska Native communities where there is no other agency assuming that responsibility.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board requests the Assistant Secretary of Indian Affairs to establish, in those agencies where there is inadequate child protective services, a separate function whose sole purpose is provision of child protective services, and that function be staffed to meet the minimum standards for staffing of child protective services.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

Resolution 1-80-DD

TRAINING OF ALCOHOL AND DRUG ABUSE WORKERS IN DETECTING CHILD ABUSE

WHEREAS, the majority of families in which child neglect occurs in Indian and Alaska Native communities are also families troubled by alcoholism:

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board requests the inclusion of the effects of alcoholism and neglect upon the children in the training, continuing education and supervision of alcohol and drug abuse workers.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

Resolution 1-80-EE

INSTITUTION CHILD ABUSE

WHEREAS, abuse still occurs in boarding and other schools and child care institutions attended by Indian children and this abuse has a lasting effect upon the Indian child in their self concept and their perception of the use of discipline,

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board study resources, that the Indian people have to resolve these problems and bring to a halt the abuse, and that the National Indian Health Board promote the concept that tribal courts have jurisdiction when Indian children are suspected of being abused in any institution.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

Resolution 1-80-FF

PLANNING AND MANAGEMENT MONIES FOR P.L. 94-437

WHEREAS, tribes facilitate their evaluation of Indian Health Service and plan only when there are tribal health staff available to do the specific work necessary; and

WHEREAS, supervisor and planning monies are not available to many tribes but are needed in order to plan and administer health programs.

NOW, THEREFORE BE IT RESOLVED, that P.L. 94-437 implementation provide for continual funding at planning and management capabilities for Tribal Health Departments.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

Resolution 1-80-GG

ELIMINATE MANDATORY USE OF THE RESOURCE ALLOCATION CRITERIA (RAC)

WHEREAS, the Resource Allocation Criteria is a compilation of Indian Health Service health care priorities delivering system preferences and funding priorities/limitations and does not necessarily reflect tribal preferences and needs in these areas.

NOW, THEREFORE BE IT RESOLVED, that 94-437 implementation should not specify the use of the (RAC) document to determine unmet needs but rely on tribal descriptions, provided that respective tribes request using their descriptions.

CERTIFICATION

It is hereby certified that a regular meeting of the National Indian Health Board held in Tucson, Arizona, January 29-30, 1980, the foregoing resolution was presented and approved by a majority vote of those Board of Directors present.

Howard E. Tommie, Chairman

NATIONAL INDIAN HEALTH BOARD NON-PROFIT SEAL COLORADO

LOW LEVEL RADIATION

WHEREAS, the Native American population within the United States has been seriously affected by the release of low-level ionizing radiation as a result of nuclear development, particularly uranium exploration, mining, and milling; and

WHEREAS, due to the presence of large amounts of uranium on and near reservations, the Native American population is likely to be exposed to even greater amounts of radiation; and

WHEREAS, exposure to radiation has caused and will continue to cause greater effects on Native Americans than on the general population due to factors unique to Native ways of life and beliefs and to comparative population size; and

WHEREAS, these effects have not been recognized, studied, or ameliorated by any government agency.

NOW, THEREFORE BE IT RESOLVED, that the National Indian Health Board actively pursue the immediate creation within the Indian Health Service of an independent Department of Radiological Health to:

1. Provide funding for non-governmental agencies to investigate the current extent of damage to Native Americans and their environment from low-level radiation, including follow-up on presently existing studies and initiation of new studies as requested by those who have been or may be affected;

2. Educate Indian Health Service personnel on the impacts of uranium mining and milling, nuclear waste disposal, and low-level ionizing on Indian peoples, their environment and foods;

3. Train Indian Health Service personnel and concerned laypersons to educate Native Americans on resources and radiation through workshops and other methods, insuring at all times that such information be useful and understandable in reservation environments; and train personnel to provide treatment for acute radiation exposure and to recognize the effects of low-level radiation.

4. Actively pressure other government and non-government agencies to recognize the dangers to Native Americans from low-level radiation and to take corrective action immediately.

5. Secure and provide complete and comprehensive studies on and projections of impacts that will result from any undertaking that may release radiation into Native American populations; fully disclose such impacts to the persons potentially affected as soon as such potential effects are known, and secure those persons' approval before commencing any such activity; and act to mitigate the effects of that activity in every possible way;

6. Provide ongoing support for and monitoring of any activities initiated by that Department.

NOW, THEREFORE BE IT RESOLVED, that preparation of reports, information dissemination, and decisions on what specific studies and activities will be undertaken by the Department of Radiological Health or other agencies concerned with radiation exposure to Native Americans to be controlled and supervised by Native persons; and

BE IT FURTHER RESOLVED, that such Department be created in such a way as to minimize or eradicate governmental conflicts of interest in regulation, dissemination of information and supervision; and

BE IT FURTHER RESOLVED, that studies undertaken by such Department or other agencies concerned with radiation exposure to Native Americans prior to any radiation-releasing activity include:

1. Complete baseline health studies of Indian receptor populations, with special reference to conditions which may correlate with increased susceptibility to radiation;

2. Computation of all other factors relevant to adverse impacts from radiation doses;

3. Computation by reliable, state-of-the-art methods of projected radiation doses, including immersion, inhalation, organ and whole body doses to Native American receptors;
4. Quantification, within narrow and conservative limits, of health risks to Indian people and resources;

5. Specific technical measures that will be taken to mitigate adverse effects from such radiation-releasing activity; and

BE IT FURTHER RESOLVED, that the National Indian Health Board set up a work group that represents the various geographical areas of the United States to act as a clearinghouse for information concerning radiation impacts on Native Americans and concerning the activities of the proposed Department of Radiological Health; and

BE IT FURTHER RESOLVED, that an Indian representative be appointed to that part of OSHA which has decision-making authority with respect to radiation in the workplace; and

BE IT FURTHER RESOLVED, that the National Indian Health Board be authorized to intervene on behalf of Indian tribes with respect to activities on or near reservations where nuclear development is proposed or taking place and to gather and disseminate information on proposed or current development; and

BE IT FURTHER RESOLVED, that the Council of Energy Resource Tribes be contacted and involved regarding the health aspects of radiation and energy development; and

BE IT FURTHER RESOLVED, that the National Indian Health Board take an active role in support of compensation to persons adversely affected by radiation and their families.

CERTIFICATION

It is hereby certified that at a regularly scheduled quarterly meeting held in Ft. Lauderdale, Florida, September 17-20, 1979, the foregoing resolution was presented and approved by a majority of the National Indian Health Board of Directors present.

Howard E. Tommie, Chairman

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